TENNESSEE EARLY INTERVENTION SYSTEM

2006 Analysis Report and Recommendations

March 2007

Governor's Office of Children's Care Coordination

and

Tennessee Department of Education

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EXECUTIVE SUMMARY

At the request of the Department of Education Commissioner, in Spring of 2006, the Governor's Office of Children's Care Coordination and Department Of Education undertook a policy analysis of Tennessee's Early Intervention System to examine ways in which the program might operate more efficiently and serve more children. The Tennessee Department of Health Children's Special Services (CSS) and the Division of Mental Retardation Services (DMRS) participated in the analysis in recognition of their roles and to broaden and strengthen additional components of children's Early Intervention services for children from birth to five years of age. Emerald Consultants, LLC, nationally recognized experts who have assisted numerous states in conducting similar analyses, provided guidance and statistical support for the financial foundation of the system.

Tennessee's Early Intervention System (TEIS) is a $34M program governed by state rules and regulations and Federal requirements of Part C of the Individuals with Disabilities Education Act (IDEA). The amount of TennCare dollars and resources of Children's Special Services which contribute to TEIS are being determined.

TEIS FUND SOURCES	
State Appropriations	**$26.3M**
Federal Revenue	**$7.9M**
Total	**$34.2M**

The terms TEIS, Early Intervention, and Part C are often used interchangeably. TEIS is Tennessee's coordination system for services identified in an Individualized Family Service Plan (IFSP) to assist eligible families. Early Intervention services are those provided to children, birth to three years, which are funded by the State but which may also be funded by Federal Part C funds as Payor of Last Resort. Part C federal funds are to be used for coordination of Early Intervention services. Part C is an entitlement program for families whose children, age birth to three years, are eligible because of developmental delays or serious medical conditions. The law entitles families to Eligibility Determination Services, Service Coordination and an IFSP. The goal of early intervention services is for a child to develop skills equivalent to those of a typically developing peer, by working with the family and other care-givers in Natural Environments.

In December 2006 TEIS was serving 5400 families—4200 eligible families with IFSPs and 1200 families in the process of assessment for eligibility. It costs approximately $4500 per child for Direct Service from all fund sources, for the 8000 children served with IFSPs throughout the year. Families are typically in service an average of 14 months.

The scope of the Analysis was a comprehensive assessment of the ***Service System***, ***Administration***, and ***Financing*** of TEIS. Groups of Key Informants and Stakeholders focused on Part C required services and administration of the State's Point of Entry Offices; State level administrators addressed accountability for resources and administration of the Early

Intervention system; and Emerald Consultants, Inc. performed analysis of the Financial component of the system.

Summary of Recommendations

The Analysis resulted in the following principal recommendations to reform TEIS

- Streamline Eligibility Determination. Strengthen Service Coordination in a new service model. Fully fund both services. Develop functional Individualized Family Service Plans built on routines based family assessments. [Reform Document 1]
  - **Estimated Cost: $2.4M**

- Unify TEIS, Tennessee Infant Parent Services (TIPS) and Early Intervention resources of the Division of Mental Retardation Services (DMRS) through reorganization of State and District level administration, aligned with the new service model. Reduce the number of administrative positions in the programs collectively statewide from 110 to 54. [Reform Document 2]
  - **Estimated Cost Savings: $5.7M**

- Define and provide a new program of state Early Intervention services for families whose children are not eligible for Part B services at age 3 years when TEIS services are no longer available to them under the existing model, and who await entry into Pre-K programs. Fund new services with resources from administrative cost savings from the reorganization. (1200 children @ $2000 ea.)
  - **Estimated Cost: $2.4M**

- Leverage federal Medicaid dollars for Developmental Therapy with a portion of current state appropriations; implement other fund expansion opportunities.
  - **Estimated Revenue: $10M**

Actions to implement the recommendations will occur in phases. Changes in State level administration will occur by July 2007; four or more of nine Districts will convert to align with the new service and administrative model October 2007; and the remainder of the nine Districts will convert to the model by year end 2007.

The reform of TEIS resulting from the Analysis will build on the system's current strengths and create new opportunities for Tennessee families. It will guide TEIS toward an efficient, effective service and administrative system to provide as many Tennessee families as possible with quality Early Intervention Services.

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INTRODUCTION

In September 2005, Tennessee's Department of Education Commissioner and the Governor's Office of Children's Care Coordination (GOCCC) began discussions regarding the need to evaluate and possibly reorganize the Tennessee Early Intervention System (TEIS). In Spring of 2006, the GOCCC and Department Of Education (DOE) undertook a policy analysis of TEIS to examine ways in which the system might operate more efficiently and serve more children. The Tennessee Department of Health Children's Special Services (CSS) and the Division of Mental Retardation Services (DMRS) also participated in the analysis in recognition of their roles in the Early Intervention system and to broaden and strengthen additional components of Early Intervention services for children from birth to five years of age.

The following is a report of the findings and recommendations of this policy analysis and is presented to Commissioner Seivers, the Children's Cabinet and Governor Phil Bredesen for consideration. The report is a product of an open and deliberate public process that involved Stakeholders who are knowledgeable and committed to serving Tennessee's children and improving Tennessee's Early Intervention System, and experts in financing of Early Intervention services.

BACKGROUND

Tennessee's Early Intervention System (TEIS) is a $34M program governed by state rules and regulations and Federal requirements of Part C of the Individuals with Disabilities Education Act (IDEA). The amount of TennCare dollars and resources of Children's Special Services which contribute to TEIS are being determined.

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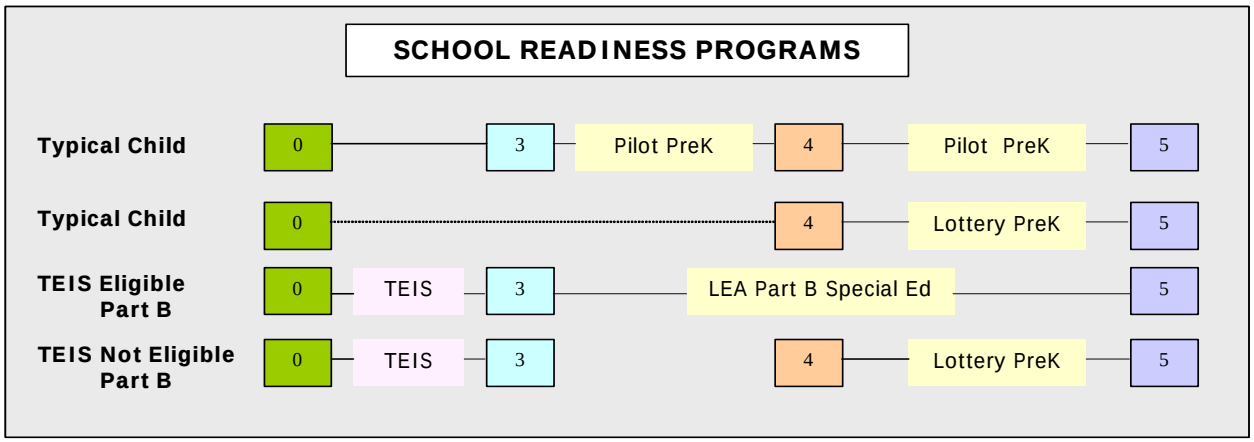
developing peer or to develop to their fullest potential, by working with the family and other care-givers in Natural Environments.

In December 2006 TEIS was serving 5400 families—4200 eligible families with current IFSPs and 1200 families in the eligibility process. It costs approximately $4500 per child for Direct Service from all fund sources, for the 8000 children served with IFSPs throughout the year. Families are typically in service an average of 14 months.

The principle components of the current System are

- TEIS Point of Entry Offices (POEs) located in nine districts throughout the state responsible for Eligibility Determination, Service Coordination and development of IFSPs.
- Tennessee Infant Parent Services (TIPS), a statewide program of developmental services and supports for families in Natural Environments based on a curriculum developed in Utah.
- Early Intervention programs which are both agency-based and offered in Natural Environments that contract with the Division of Mental Retardation Services (DMRS).
- Private providers of speech/language, occupational and physical therapy services and other required services.
- Children's Special Services (CSS) of the Department of Health (DOH) which provides clinic based medical services and adaptive equipment through local and county health departments, and other home-based services through a variety of additional DOH programs.

TEIS is a significant component of Early Childhood and School Readiness programs which extend from birth to five years. Early Intervention services focus on family centered child development from birth to 3 years, and are prerequisites for school readiness. TEIS is depicted next in relation to other School Readiness Programs for children from birth to five years of age.



POLICY ANALYSIS

The 2006 Analysis of TEIS was initiated by the Commissioner of the Department of Education (DOE), the Part C Lead Agency, and led by the Governor's Office of Children's Care Coordination (GOCCC). The Analysis was prompted by several factors: Steady growth in early intervention resources but no concomitant increase in the number of families served. The

program had experienced cost overruns three consecutive fiscal years. The option became available in the federal law to extend services up to age five for children who are eligible for Part B, however, without additional federal resources for that purpose. Last, it is the policy of the Administration to manage state government effectively and efficiently. This program did not meet those criteria. Each of the factors contributed to the timeliness of the Analysis.

Summary of Recommendations

The Analysis resulted in the following principal recommendations to reform TEIS

- Streamline Eligibility Determination. Strengthen Service Coordination in a new service model. Fully fund both services. Develop functional Individualized Family Service Plans built on routines based family assessments. [Reform Document 1]
  - **Estimated Cost: $2.4M**

- Unify TEIS, Tennessee Infant Parent Services (TIPS) and Early Intervention resources of the Division of Mental Retardation Services (DMRS) through reorganization of State and District level administration, aligned with the new service model. Reduce the number of administrative positions in the programs collectively statewide from 110 to 54. [Reform Document 2]
  - **Estimated Cost Savings: $5.7M**

- Define and provide a new program of state Early Intervention services for families whose children are not eligible for Part B services at age 3 years when TEIS services are no longer available to them under the existing model and who await entry into Pre-K programs. Fund new services with resources from administrative cost savings from the reorganization. (1200 children @ $2000 ea.)
  - **Estimated Cost: $2.4M**

- Leverage federal Medicaid dollars for Developmental Therapy with a portion of current state appropriations; implement other fund expansion opportunities.
  - **Estimated Revenue: $10M**

Elaboration on these and additional recommendations follow on pages 12 through 41.

Objectives of the Analysis

The objectives of the Analysis were to:

- Describe the current service system for children, birth to age three, with developmental delays or serious medical conditions which are likely to result in developmental delay, including services and funding of TEIS, TIPS, Early Intervention in DMRS, CSS, Head Start, Early Head Start, Special Education, TennCare and other related components;
- Identify service gaps, obstacles to service delivery, and areas of unnecessary duplication, including program administration, as well as system strengths;
- Identify the total amount available from all sources for services and program administration and recommend approaches to maximize the total;
- Assure sound business practices for objectivity and accountability.
- Apply research findings that can help shape appropriate system reform.

- Generate a set of recommendations to reform the system for immediate and long term stability and growth.

Principles for the Analysis

The Analysis was guided by these Principles, which incorporated the Mission Statement and Beliefs about TEIS by reference, detailed on the TEIS website at www.state.tn.us/education/speced/TEIS:

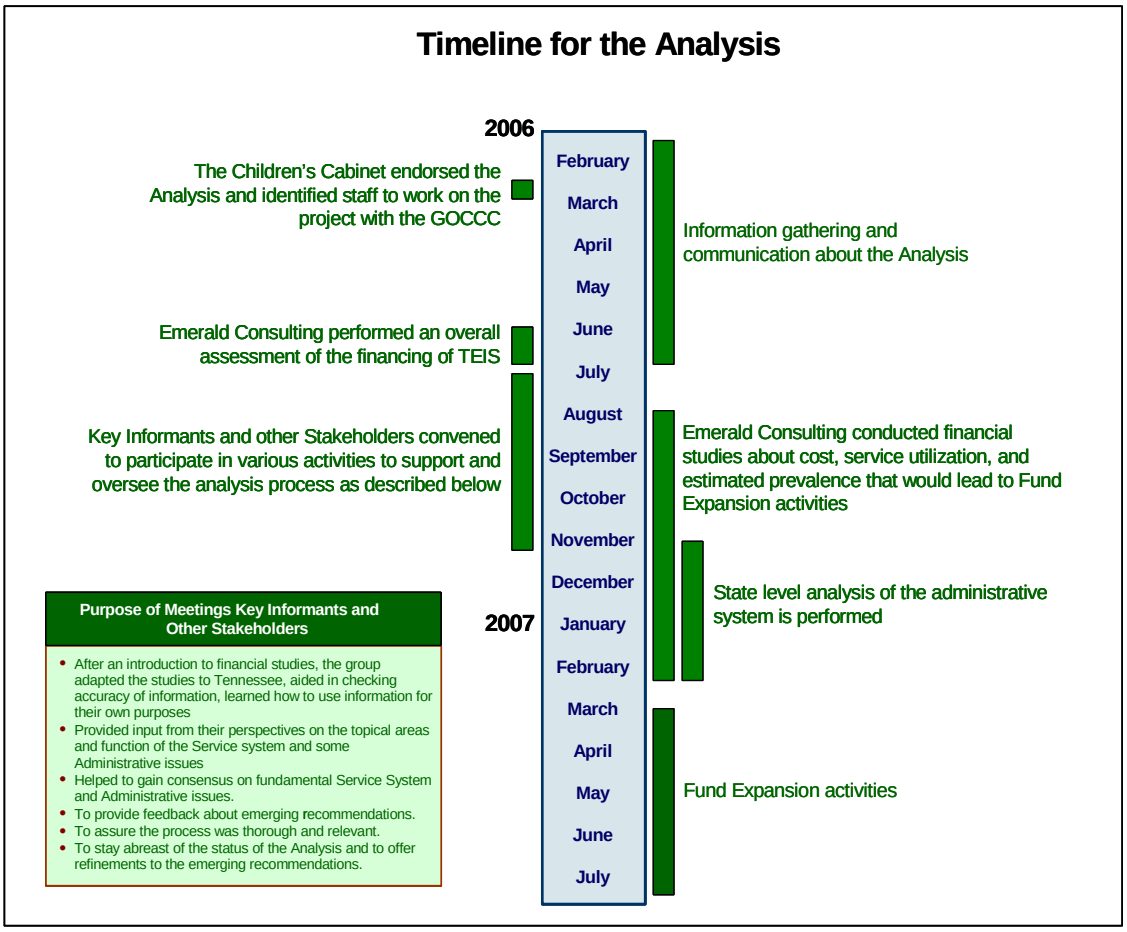
- The first consideration are the needs of families with children, age birth to three years, who have conditions that have a high probability of resulting in developmental delays.
- Services are to be offered to families of children with special needs in the most Natural Environments, close to home, and with children of all abilities.
- Families are to be provided with access to quality individualized services to which they are entitled under the law.
- Parents are the experts regarding their children, and a child's early intervention program is to be based largely upon parental concerns, family routines and priorities as they relate to the child's developmental needs.
- Parents' self-reliance in decision-making about services and competence as caregivers are important indicators of family empowerment.
- Requisites for a comprehensive system of early intervention services and for meeting the needs of eligible children and their families are a collaborative development, promotion and coordination of community resources.
- A statewide network of district level "Points of Entry" and a statewide toll-free telephone number are to assist families and to defray costs in accessing the Early Intervention System.
- Needs of the child and family define the service system, not the funding sources that determine for what the funding sources are willing to pay.
- Interagency collaboration is intended to secure long term partnerships on behalf of families.
- Federal Early Intervention funds are to be used to pay for services only after all other payor sources have been exhausted in fulfilling the IFSP requirements.
- Results of the Analysis are intended to achieve the objectives stated before.
- Recommendations to strengthen the Early Intervention System adopted by the Leadership Team for the Analysis will be implemented timely and evaluated for effectiveness.

Outcomes of the Analysis

Outcomes of the Analysis include description of the size, scope and financing of Part C related services in Tennessee; the system's strengths and opportunities for improvement; consensus about the optimal Early Intervention system, its funding and administration; a set of recommendations for achieving the optimal system and a framework for implementation of recommendations which strengthen TEIS administratively, programmatically and financially, consistent with a family centered, child focused philosophy.

Analysis Structure and Process

The scope of the Analysis was a comprehensive assessment of the ***Service System***, ***Administration***, and ***Financing*** of TEIS. The Analysis took place over a period of one year.



Service System Analysis

Key Informants and Stakeholders addressed the elements of optimal Early InterventionI services; services to be offered, how and by whom, in compliance with Federal Part C requirements; and potential State offerings, all in the context of best practice guidelines.

Key Informant groups focused on Service System issues related to:

- Child Find and Public Awareness
- Eligibility Determination and IFSP Development
- Interagency Planning and Service Coordination
- Direct Services
- Points of Entry Functions and Roles of Principle Investigators.

In a series of public meetings, Key Informants and Stakeholders considered information and grassroots experiences related to the current system, relevant data, best practices, models from other states and Key Informant input, supplemented by compilations of responses to questionnaires completed by Stakeholders statewide about the topical areas. The questionnaires were developed to assure input from the field. They were not intended to be scientifically rigorous. [Attachment 1]

Work of Key Informants resulted in more in-depth consideration of 15 functions about which there was consensus that required that the concepts be refined; or for which additional technical or specific information was needed; or where problem solving required additional perspectives.

Administrative System Analysis

Commissioner level administrators addressed oversight and promotion of an optimal system; most efficient, effective administrative arrangements; quality assurance mechanisms and business practices, prioritizing families first.

Administrators focused on:

- Accountability for Resources
- Administration of the System
- State Assurances with Part C Payor of Last Resort Requirements and other financial issues.

Financial Analysis

The fundamental question of the Financial Analysis was how to maximize federal, state and private resources appropriately to support extant, planned and future service system opportunities.

To assure an objective assessment of resources in the Early Intervention system, Emerald Consultants, LLC, and associates, experts in Part C financing, were engaged to determine the resources in the system. Business rules and types and methods of data collection were agreed to by all parties prior to data collection. Principles of Emerald Consultants and Solutions Consulting Group, LLC, performed the following:

- An Estimated Prevalence Study in collaboration with Core Staff and Point of Entry Offices.
- A Service Utilization Study which relied primarily on data exchange with State agencies.
- A Cost Study comprised of provider Costs, Revenues and Time surveys.
- Fund Expansion Activities. These activities were initiated during the Analysis and will continue through the end of FY 07. Fund Expansion Activities identify new sources of revenue, opportunities to leverage additional dollars or expand service support through collaborative relationships.

Staff Support for the Analysis

The Analysis was organized, staffed and documented by the GOCCC in collaboration with Core Staff of Division of Special Education's Office of Early Childhood Programs (OEC), TIPS; DMRS; CSS; Head Start; Department of Mental Health and Developmental Disabilities (DMHDD) and TennCare. The Assistant Director, GOCCC, served as an in-house consultant to the project.

Organization of this Report

The template for the Report of Part I: Service System Concepts and Recommendations and Part II: Administration Concepts and Recommendations considered during the Analysis is:

- Background: the topics considered by Key Informants and Stakeholders.
- Findings: Substantive areas considered during the process to gain consensus about issues and recommendations, and a narrative discussion of current conditions.
- Best Practices derived from research or models from other states or from within Tennessee.
- Recommendations that contribute to overall reform of TEIS.
- Estimated Costs.

Recommendations to reform TEIS follow and include Part I. Service System Concepts and Recommendations and Part II. Administrative System Concepts and Recommendations.

Part I. Service System Concepts and Recommendations

CHILD FIND

Background
Child Find is defined in IDEA as a comprehensive child find system, consistent with part B, including a system for making referrals to service providers that includes timelines and provides for participation by primary referral sources and that ensures rigorous standards for appropriately identifying infants and toddlers with disabilities for services under this part that will reduce the need for future services. (Sec. 635)

Tennessee rules define "Comprehensive Child Find system" as a total system that is consistent with IDEA and TEIS Policies and Procedures. It is coordinated with all other major efforts conducted by all State Agencies responsible for administering the various education, health, and social service programs relevant to IDEA Part C to locate, evaluate, and identify children with disabilities. It includes children in traditionally underserved populations including, minority, low income, children living in rural communities, and children living in urban communities and highly mobile children (e.g., migrant and homeless children) residing in Tennessee, and who are in need of early intervention services. Child Find includes the process developed and implemented to determine which children are receiving needed early intervention services.

Key Informants and Stakeholders considered issues and Best Practices about variables contributing to the low rate of Child Find results; assessment process and tools; eligibility criteria; where Child Find is most effective and why; what is being done to reach families of children with autism and behavior problems; accessibility of POEs; opportunities to use Early Periodic Screening Diagnosis and Treatment (EPSDT) services as a Child Find mechanism; and strengths and shortcomings of current Public Awareness activities; among other considerations.

Findings
Tennessee falls below the national average in the number of children in service. Tennessee reports 1.80% of Tennessee children, age birth to 3 years, are referred for eligibility determination under Part C compared to 2.04% for other states with a narrow eligibility category according to OSEP's Rank Order Data, and 1.80% compared to the National Baseline of 2.4%. In addition to the low percentage of children served, the number of children determined to be eligible is low compared to the number of referrals. The number of children served is particularly low among the families who would seem to be most at risk according to the Demographic Profile and Estimated Prevalence data compiled for the Analysis.

Variability in Eligibility Determination processes contribute to low rates of children served. A variety of assessment tools and processes have been used to screen and assess children. Also, diagnoses and medical conditions have not been applied consistently in authorizing automatic eligibility. Only two of nine Point of Entry (POE) District offices use diagnoses/medical conditions lists and they vary from each other. In Tennessee, a Commissioner-appointed Part C Financial Task Force (8/05) recommended that the State develop a list of diagnosed physical

or mental conditions that have a high probability of resulting in developmental delays, but that recommendation was not implemented.

Best Practices

OSEP funded demonstration projects in six states concerning Part C Child Find activities which may serve as models for Tennessee. The projects included

- Improving the rate of referrals from county child welfare departments to local Part C services (Colorado).
- Recruiting Stakeholders to target professionals rather than parents or the general public (Hawaii).
- Providing education on newborn hearing screening to couples awaiting births and support to families of babies referred to follow-up testing or on to services (Connecticut).
- Enhancing capacity of pediatric healthcare practitioners and early interventionists (Vermont).
- Synthesizing a variety of approaches to address earliest possible identification (New Hampshire).
- A process model child find programs that are replicable in rural communities (Montana).

Taking into consideration other models, additionally, this Analysis endorses the Part C Financial Task Force recommendation to formulate and authorize a list of medical diagnoses and conditions which will result in automatic eligibility to ensure consistency in eligibility determination. Research on developmental disorders permits new and increasingly discreet diagnoses to be identified on an on-going basis. However, statewide, standard criteria have not existed upon which to base eligibility attributable to medical conditions and syndromes. Currently two districts use lists unique to each district; the remaining districts do not have lists for this purpose.

Another approach to more consistent Child Find is to limit the number of tools for each of the Screening, Eligibility Determination and Child Progress functions. This will assure greater reliability and consistency in the processes and permit more accountability. Tools to establish eligibility are not good curriculum guides for development of IFSPs. However, it is important for the State to limit the assessment tools to those most appropriate for Screening, Eligibility Determination, tracking progress, and to assure competent use of them.

Criteria for selecting tools to be used for Screening, Eligibility Determination and On-going Assessment included Inter-rater reliability; Recency of norming; National norming; Inclusive of all domains; Discipline free; Administratively time-efficient; Training necessary for administration; Closes the gaps between medical and developmental considerations; and Measures changes over time for ongoing assessments. The latter is expressly to meet OSEP requirements.

The State has an excellent program, Screening Tools and Referral Training (START), to reach physicians and allied health care professionals to educate them about developmental delays, the value of early intervention services and how to access the services. Spearheaded by one member of Tennessee Chapter of the American Academy of Pediatrics (TNAAP), the program helps practices

- Increase early identification of children with developmental delays or behavioral problems using standardized screening tools without adding significantly more time to office visits.
- Better understand how to refer children to community services.
- Learn how to code for reimbursement of the services.

The program couples use of the tools with routine clinical surveillance. Using a Train The

Trainer Model, in FY06 START reached 145 doctors, 163 staff and 22 other participants from 60 physician practices. In follow up evaluation, of the 30 doctors who responded

- 93% reported using the recommended standardized tools.
- 48% reported increased identification and referrals.
- 59% reported increased patient satisfaction.
- 76% reported reimbursement by most payors.

Recommendations to Increase Child Find

1. Assure greater consistency in determining eligibility statewide.
    a. Implement an authoritative list of Diagnoses/Medical Conditions that have a high probability of resulting in developmental delays. [Reform Document 3]
        i. Families of children whose conditions are listed on the State authorized list of Diagnoses/Medical Conditions will automatically be eligible for services. Not only does this ensure greater consistency, it addresses a rights issue. Given the same conditions, families have the right to expect the same eligibility determination results regardless of where they live in the state.
        ii. Establish a process to permit eligibility for diagnoses which are not on the list:
            a. Exceptions to the State list may be made only for rare genetic conditions for which there is literature to support the premise that, without intervention, the condition will likely result in developmental delay.
            b. In such instances, the District Eligibility Coordinator will provide medical documentation to CSS Nurse Consultant that the condition has a probability of resulting in developmental delay. Within 3 business days, CSS will provide medical consultation in the process of eligibility determination, erring on the side of the child. If authorized, routine ongoing assessments will be done thereafter.
        iii. Establish a process for periodic review and updating of the Statewide list. Semiannually the CSS Nurse Consultant will provide the State with a summary of the types and incidences of diagnoses for which exceptions to the approved list were requested; disposition of the exceptional cases; and recommendations with justifications for revisions to the approved list, if any. The State will act on the recommendations, adopting some or all or none.
    b. Limit the number of assessment tools to assure greater reliability and consistency in Screening, Eligibility Determination and Ongoing Assessment of Child Progress to comply with OSEP requirements. Special provisions will be made for families who are unable to read and/or are non-English speaking. Alternate instruments are to be permitted for children whose progress and ability require use of physical supports.
    c. Annually, District Eligibility Coordinators and OEC, in collaboration with TNAAP, will review currency of the tools, particularly as they relate to sensitivity for social-emotional screening.

The tools recommended to be used statewide are

- Pre-referral Screenings for Child Find
    - in community-wide activities: Ages & Stages
    - in smaller venues, one on one with child: Denver II
- Post-referral Screenings during Intake meetings: BDI-II Screener
- Eligibility and Ongoing Assessments: Battelle 2 BDI-II

2. Use Estimated Prevalence data gained in this Analysis plus Tennessee Early Intervention Data System (TEIDS) information to target counties with the most growth to accomplish (>5%). This permits a data-based approach to identifying where the State can seek families who might benefit from TEIS. Incorporate the activities of START into targeted Child Find plans.
3. Maintain current eligibility criteria during the reform period of TEIS. Thereafter, use data gained during this analysis and TEIDS data to include more families to the extent possible, aligned with anticipated Federal guidelines for states to establish "rigorous" definitions of developmental delay.
4. Establish and sustain consistent relationships with
    a. Local public health agencies, including establishing TEIS presence in those locations, because the local health department is where families of young children come to obtain services. The focus should be that of Well Child Services as Developmental Disability is not an illness.
    b. Neonatal Intensive Care Units statewide.
    c. Federally qualified health centers.
    d. Homeless shelters.
    e. Tennessee Chapter of the American Academy of Pediatrics (TNAAP).
    f. Tennessee Perinatal Association.
5. Bridge TEIS, DMRS, CSS and other Child Information systems so that services will not be duplicated.
    a. Near-term, engage Office of Information Resources as it develops a protocol for electronic medical records. The purpose is to facilitate identification of a minimum set of data elements which will permit an authorized user in one child serving agency to know if a child or family is also in the service of another child agency.
    b. Long-term, establish a uniform centralized intake instrument to eliminate redundant intake processes and increase consistency in data management in state services.
    c. Long-term, implement a statewide uniform external referral form to ease referrals to TEIS by physicians and other professionals. Examples are prescription pads with a referral to TEIS.

Estimated Costs: Local Administration $122,400

PUBLIC AWARENESS

Background

Public Awareness is defined in IDEA as a program focusing on early identification of infants and toddlers with disabilities, including the preparation and dissemination by the lead agency designated or established under paragraph (10) of the law to all primary referral sources, especially hospitals and physicians, of information to be given to parents, especially to inform parents with premature infants, or infants with other physical risk factors associated with learning or developmental complications, on the availability of early intervention services and of services under section 619, and procedures for assisting sources in disseminating information to parents of infants and toddlers with disabilities.

"Public Awareness Program" in Tennessee means the program that focuses on the early identification of children who are eligible to receive early intervention services and includes the preparation and dissemination of materials by the lead agency to all primary referral sources and parents on the availability of early intervention services. The program must inform the

public about the early intervention system, the Child Find system, and the central directory which is a system-wide directory of information about public and private early intervention services, resources, and experts available in the State; research and demonstration projects being conducted in the State; and professional and other groups that provide assistance to children eligible under IDEA Part C and their families.

Key Informants and Stakeholders considered issues and Best Practices about Public Awareness activities and funding; TIPS Infant-Toddler Helpline Project; components of effective social marketing; diverse populations represented in the state, and ancillary effects of increasing Public Awareness and Child Find, such as increasing the demand for bi-lingual and culturally sensitive response systems.

Findings

The current Public Awareness program is not reaching all families who could likely benefit from services. For example, Shelby County includes some of the poorest zip codes in the state with the highest rates of community risks. Yet it has the lowest number of enrolled families. This characterizes a Public Awareness shortcoming as well as a Child Find problem. Also there are no focused public awareness strategies to reach all families statewide generally, nor are there strategies to reach the increasingly diverse population of the State. One message does not reach all. Another consideration is that the term TEIS is meaningful to those familiar with the service but it can be misinterpreted for other prevention/early intervention services like substance abuse.

TEIS has good publications and printing capacity arranged through one POE contract. However, limitations are that there is no comprehensive plan nor priorities established to guide the design and development of materials and expenditures. TEIS District Offices make individual requests for assistance with public awareness materials, which is appropriate to the extent that District needs vary. The variances need to be considered within an overall, intentional approach to raise the visibility of the system and how to gain access to it.

Long-term implications of successfully addressing Public Awareness about TEIS can be derived from that of the nonprofit sector:

- TEIS will be seen as a positive force.
- There will be increased understanding and support for the services.
- Individuals will become more involved as advocates.
- More professionals will want to be a part of the system.
- The public will understand that eligible families from all socio-economic strata can benefit from services, thus promoting inclusion of all people in Natural Environments.
- TEIS will be better able to achieve its mission because of a clearly communicated message.

There are valuable tools in place but there needs to be a clear, statewide message that is recognizable and attractive to families. TEIS may benefit by approaching Public Awareness from a social marketing perspective, identifying target audiences and determining the best approaches to reach them.

Best Practices

TEIS may benefit from best practices being advanced in the nonprofit sector, according to the National Council of Nonprofit Associations:

- Establish spokespeople for the system
- Document benefits of TEIS to the public and to businesses

- Use technology such as blogs and webcasts to promote the service
- Establish a “tagline” to follow TEIS as the brand
- Influence locally produced programs to incorporate TEIS into their productions.
- Demonstrate strong unity and collaboration in developing public messages.
- Decrease fragmentation through increased networking with peer providers.
- Develop grassroots support among families to help communicate the values of the system.
- Communicate key messages about TEIS to the nonprofit community at large.

Recommendations to Increase Public Awareness

6. Establish state-level Public Awareness and Child Find policies and strategies.
    a. Establish a state-level position in OEC to
        i. Develop and coordinate a consistent communications/public awareness program.
        ii. Master the unique variations throughout the state and tailor the PA program with local strategies
        iii. Utilize relevant demographic and other information to target Child Find activities to counties with the largest amount of growth to accomplish
    b. Provide for printing and publications capacity in the Advisory Consortium, coupled with that available in DOE.
7. Develop and implement a comprehensive Public Awareness plan in collaboration with key informants and marketing professionals.
    a. Identify clear goals and methods to increase the visibility of TEIS.
    b. Retain TEIS as the “brand” and develop a tag line to follow, which will be the message for use throughout all Public Awareness efforts, adaptable for use with all potential audiences, languages and in all locations. It must be a positive message about Child Development.
    c. Identify target audiences, locations and methods to reach them. [Reform Document 4.]
    d. Communicate the long-term cost benefit of Early Intervention services, notably the Abecedarian Project and Perry Preschool and Chicago Child-Parent Centers.
    e. Build on the 2005 Market Analysis done in conjunction with TIPS Infant Toddler Helpline.

Estimated Costs:

State Administration	$81,000
Publications Coordinator	$26,116
Printing/Publications	$36,000
Public Awareness Plan	$10,000

ELIGIBILITY DETERMINATION, SERVICE COORDINATION & IFSP DEVELOPMENT

Background

Key Informants and Stakeholders considered issues and Best Practices to achieve most efficient Eligibility Determination; comprehensive description of the model; staff functions; training requirements; implementation; costs; compliance with the 45 Day Timeline for developing IFSPs, and other considerations.

Findings

Eligibility Determination. Eligibility Determination, the key to families accessing Part C services, has been implemented inconsistently statewide. Eligibility Determination is characterized as burdensome to families and unnecessarily costly. The current system is provider-driven, attributable to the frequent practice of therapists performing Eligibility Determination evaluations and subsequently recommending that clinic-based therapy be provided by the agency of the evaluator. There may be instances when Eligibility Determination will require assessments by therapists, but not routinely. At the same time, in some areas of the state there is a paucity of therapists to provide IFSP services.

Service Coordination. Service coordination, defined by federal regulations is "the activities carried out by a service coordinator to assist and enable a child eligible under Part C and the child's family to receive the rights, procedural safeguards, and services that are authorized to be provided under the state's early intervention program."

Service Coordination, the root service of Part C, is a coupling of administration and direct services, sometimes referred to as Integrated/Blended Service Coordination. Statewide the average number of families is 45 to one Service Coordinator, but in some Districts the average is as high as 55. Currently Service Coordinators are principally responsible for intake into the system—a process for which there are explicit federal requirements: scheduling, organizing, participating in and documenting IFSP meetings, and periodic contact with families thereafter. With the inception of TennCare reimbursed Targeted Case Management, Service Coordinators have at least one face-to-face contact with families monthly. Administrative responsibilities include accessing insurance, assisting the family in obtaining other appropriate supports and identifying other sources of financial resources for the family. Turnover, vacancies and family leave contribute to Service Coordinators having a high number of families to serve.

The State does not fully comply with the federal requirement for the 45 day timeline within which the IFSP must be developed, in part due to demands placed on Service Coordinators. In addition to administration issues, anecdotal information suggests that many families rely on Service Coordinators for all manner of support, far beyond that associated with coordination of IFSP related objectives. One questions, then, how family empowerment is established and measured.

IFSP Development. The current Eligibility Determination process results in jargon-ridden IFSPs, over-reliance on clinic based services, and excessive costs to the system. The Pathways Project, a research project of Principle Investigators (PIs) at UTK and Tennessee Tech, indicated a high level of parental satisfaction with Service Coordination. However, the research also revealed that IFSPs are meaningful to professionals and substantially less so to families, based upon research on 300 Tennessee IFSPs containing 900 goals. Elements of Tennessee TEIDS prompt more functional goals and objectives to be written as observable behaviors and skills to work toward. Additionally, all goals will clearly be identified as either a family or a child goal. Incorporating Routines Based Family Assessments into development of the IFSP is proven to stimulate more individualized, functional objectives.

Best Practices

Eligibility Determination. Policy guidance from OSEP endorses assessment by a developmental specialist in the five developmental domains and consideration of appropriate medical information to constitute multidisciplinary assessment. Incorporated into the assessment is informed clinical judgment. The assessment constitutes best practice if:

- The approach is thorough
- Not burdensome to families

- Can occur in the Natural Environment and
- Completed in a timely manner.

It meets these Best Practice standards based on the Pathways research if:

- Performed by a qualified person
- Multidisciplinary
- family focused and
- leads to next steps. [Reform Document 5: Eligibility Policy Letter 06-002.]

Service Coordination. Research by the Research and Training Center of Service Coordination resulted in the identification of 12 exemplary practices that service coordinators should engage in order to ensure the highest quality of service coordination for children and families:

- Providing information
- Ensuring family understanding
- Being responsive to families
- Developing IFSPs
- Monitoring progress
- Ensuring family satisfaction
- Promoting child development
- Addressing healthcare and safety issues
- Completing administrative responsibilities
- Planning for transitions
- Collaborating with community organizations, and
- Engaging in professional development.

Family Empowerment has been summarized by NECTAC as

- Supporting families to be a fully informed and fully participating member of the Early Intervention team.
- Strengthening the family role as ultimate decision-maker.
- Gathering information on children's and families' usual interests, routines, activities and activities they would like to try.
- Basing outcomes, strategies, services and supports on the families' concerns, priorities and interests.
- Supporting family confidence and competence to provide their child learning opportunities and enhance participation in activities for mutual enjoyment.

Best Practices for Service Coordination in Tennessee are articulated in the 10 module required training curriculum for Service Coordinators, *Journey of Hope*.

IFSP Development.

Research indicates developmental assessments and priorities in Service Coordination are best coupled with Routines-Based Family Assessments that result in more individualized, functional and achievable IFSP [*McWilliam, R. A., & Casey, A. M. (2006, October). The routines-based interview: Preliminary data and research tribulations. Poster presented at the 22nd Annual International Conference on Young Children With Special Needs and Their Families (Division for Early Childhood of the Council for Exceptional Children*)]. Initiated by McWilliam, a recognized leader in Early Childhood programs from Vanderbilt's Center for Child Development and subsequently the subject of extensive research about the approach, the assessment entails a process in which members of the IFSP team observe the family context for routines, activities and everyday places in which interventions can be embedded throughout the day by parents and other caregivers. Research at Florida State University describes routines instructional strategies as being

- Evidence based and appropriate for the intended outcomes.
- Identified by family as useful and comfortable.
- Embedded systematically in family identified routines.
- Learned through discussion, guided by practice and triadic consultation methods.
- Monitored for progress and revised as needed.

It is incumbent upon the State to establish Routines Based Family Assessments in development of the IFSP.

Recommendations for Eligibility Determination, Service Coordination and IFSP Development

8. Streamline Eligibility Determination.
    a. The required multidisciplinary assessment will be performed by developmental specialists qualified to assess the five developmental domains and take into consideration appropriate medical information in confirming developmental delay. Developmental Specialists may be from a variety of qualified professional disciplines.
    b. Medical information will be procured by the District Eligibility Determination Coordinator in order to simplify lines of communication and build relationships with physicians. The communication system will include (1) a standard format across districts to confirm availability of relevant medical information provided as offered by physician practices and (2) a mechanism to evaluate the incidence of physicians' reluctance to endorse Early Intervention services, that is, advising "wait & see" in response to concerns about a child's possible developmental delay.
    c. Explore administration of the BDI-II using software via laptops for scoring of the assessment immediately upon completion. Results of the assessment will be considered in conjunction with relevant medical information and clinical judgment.
9. Strengthen Service Coordination.
    a. Limit the number of families served to no more than 40 families to each Service Coordinator responsible for intake processes, gaining family consent and establishing dates for initial IFSP team meetings; performing routines-based family assessments; informing and educating families about service options; and convening and leading IFSP meetings. Permit lower ratios when conditions warrant more attention than the norm as might occur with families whose children are medically fragile or children in foster care.
    b. House Service Coordinators in state or county education or health department offices, away from POE offices, when it is most time efficient in serving families, building community relationships or to build relationships with Local Education Agency (LEA) Part B Special Education programs. Require on-site presence in those locations except when performance of one's duties contraindicate.
    c. Clarify and measure functional indicators of Family Empowerment, particularly that families are making independent, informed choices.
    d. Provide families the opportunity for feedback to the Service Coordination Manager about their experiences with Eligibility Determination and IFSP development to District Service Coordination Managers. Among the variables to assess: Simplicity of Eligibility Determination; Routines based assessment reflects actual family conditions; Neutrality of education about services and providers; Awareness of limitations of service options; Respectfulness of all parties; and Cultural competence. Compile and report the results to leadership of DOE, TEIS and Interagency Coordinating Councils (ICCs).
10. Document Individualized Family Service Plans that are family oriented and functional for the child. [Reform Document 1]
    a. Service Coordinators will set the date for the IFSP meeting during Intake. Between the time eligibility is determined and the IFSP meeting, Service Coordinators will

educate families about service and provider options. Inform families about Early Periodic Screening, Diagnosis and Treatment (EPSDT) services.

b. Service Coordinators will help families gain access to TennCare, SCHIP and other programs for which they may be eligible.
c. Routines based family assessments will occur in the Natural Environments and include the core provider, if known.
d. Participants in the IFSP meeting will include the Family, Service Coordinator, Developmental Specialist and provider, if known.
e. Goals and objectives will be written as observable behaviors. Outcomes will include behaviors that can demonstrate increased independence by the family in assuming responsibility for the IFSP.

Estimated Costs:

Eligibility Determination	$1,340,000
Service Coordination	$1,100,000
IFSP Development	Cost Neutral

UNIFORM SERVICE DEFINITIONS

Background
Key Informants and Stakeholders considered Best Practices for Part C required services; definitions in the OEC contract Scope of Services; DMRS contract language; services provided through CSS; and Medicaid approved plans for reimbursable Developmental Therapy services in other states, particularly Arkansas, among other issues.

Findings
A fundamental weakness of the Early Intervention system has been lack of clear service definitions. The language in the OEC contract Scope of Services replicates the Part C Required Services. Major providers refer to their respective principle services as one of two required services, Family Training and Special Instruction. However, the services are so similar as to beg clear distinctions between them. Consensus on that, and guidance from OSEP that two or more services may be incorporated into a single service, permitted reconciliation of Family Training and Special Instruction to be the proposed definition of Developmental Therapy. [Reform document 6]

Assistive Technology was another challenging service definition. Assistive Technology is difficult to implement consistently because the amount of resources and accessibility to durable equipment vary among Districts. Also, CSS, a major provider of Assistive Technology, routinely experiences significant demands for equipment, particularly hearing aids, and thus has put limits on the types of equipment for which it can pay, especially if efficacy of the products and/or superiority over the existing models has not been established. At the same time, with the rapid advances in technology, superior products have been developed.

Best Practices
It is Best Practice to establish a standard set of service definitions to be used for system-wide communication.

Recommendations for Uniform Service Definitions

11. Adopt service definitions to be used uniformly statewide. [Reform document 6.]
    a. Replace terms and definitions for Family Training and Special Instruction with Developmental Therapy. Included in the definition for Developmental Therapy is emotional support to families and incorporation of developmental services in all components of the IFSP. It is especially important to consider the scope of Service Coordination/Targeted Case Management in composition of the Developmental Therapy service as they are different services but both require support to families.
    b. Refer to those providing direct services to families as "Developmental Therapists" who work with families to provide Developmental Therapy.
12. Develop and implement a comprehensive approach to increase access to Assistive Technology when documented on IFSPs and permit the highest quality equipment feasible, consistent with agreed upon Medical Necessity policies for TennCare supported families.
    a. Adopt the proposed expanded definition for Assistive Technology. Track the amount expended for the service through contracts and TEIDS.
    b. Develop coordinated policy in DOE for Assistive Technology, volume purchasing, and re-use of size- and age-appropriate durable equipment. Assure that all equipment is appropriate to the specific equipment needs of the child and family, based upon informed clinical judgment and not upon availability of a similar but less appropriate support. Implement the accompanying guide for equipment to be available on a rotating basis. [Reform document 7]
    c. Raise the base quality for volume equipment by expanding the scope purchasing to include CSS and Department of Children's Services, if feasible. Complement CSS and TennCare reimbursements with TEIS funds to permit access to the highest quality equipment when clinical judgment indicates.
    d. Coordinate volume purchasing policy through OEC as the Office is responsible for overall coordination of Part C related services, including Education, Health, DMRS and private providers.

Estimated Costs: Cost Neutral

CORE COMPETENCIES IN WORKFORCE DEVELOPMENT

Background

Key Informants and Stakeholders considered issues and Best Practices about training activities occurring in the State, offered by whom; logistical and financial issues of requiring staff training; levels and types of staff to which training requirements would apply; the expertise of academia needed to develop specialized training for service delivery for special populations; training models of other states; roles of mentors; the process of skill building and skill practicing; Service Coordinator training, *Journey of Hope*, and Core Competencies in the context of workforce development.

Findings

The State has made significant investments in training in Early Childhood services, yet training in TEIS has been described as under-funded. Within TEIS, there have been limited contract funds for training and technical assistance. That small amount, $246,000, does not represent all the training occurring in the State.

TIPS has a historical commitment to the SkiHi curriculum, developed in Utah, for staff who provide services directly to families. Five staff of TIPS, certified instructors in the SkiHi curriculum, provide training to part time staff in the Tennessee program and in other states. Eleven Childhood Care Resource and Referral (CCR&R) agencies offer a cadre of programs, services and training opportunities to help all child care agencies meet and exceed Department of Human Services and DMRS licensure requirements. Over 16,900 staff from 2872 agencies participated in CCR&R statewide training programs in CY06. Statewide, about 10,700 staff from 4062 agencies participated in CCR&R on-site technical assistance programs in CY06. Additionally, Tennessee Early Child Training Alliance (TECTA) is a highly regarded statewide training system in community colleges which provides a 30 hour basic orientation that is a prerequisite for and leads to degreed programs in early childhood services. And recently, Higher Education has initiated a curriculum focused on Pre-K credentials.

Best Practices

Work of other states provide models for core competencies, credentialing and approaches for training that can be adapted for Tennessee. Connecticut and New Mexico have well developed programs. The state should establish long-term partnerships with TECTA for training and credentialing in core competency curricula for all early childhood professionals in Tennessee, rather than developing a competing parallel system of training for only special needs populations, and similarly with CCR&R agencies. Relationships with and financial support of TECTA and CCR&R are expected to grow over time. Incorporate TEIS Service Coordinator training modules extant, as appropriate.

Recommendations for Core Competencies

13. Establish state level Training and Workforce Development policies and training capacity.
    a. Establish a state level position in OEC to develop and maintain quality training and workforce development plans and strategies to be implemented in TEIS Districts.
    b. Establish a three person team to provide training and on-going mentoring of direct service providers in collaboration with TEIS Districts and in keeping with the approaches developed for Core Competencies.
    c. Evaluate the need for additional trainers/mentors during the initial phase of reform.
    d. Establish a training consortium in collaboration with CSS and DMRS to create shared workforce development opportunities.
14. Structure and fund approaches to assure Core Competencies for all service providers as a part of ongoing Workforce Development. [Reform Document 8] Implement initial strategies:
    a. Provide Service Coordinators and Managers, Eligibility Specialists and Managers, and program directors in-depth training in the principles of the Reform which result from the Analysis, as they will be the most influential persons operationalizing TEIS reforms.
    b. During FY08, within the Scope of Services, require staff of contract agencies and District staff to participate in 10-12 hours in relevant training offered at no cost by CCR&R agencies, the State or its approved contractors.
    c. Establish partnerships with TECTA and professional associations to create Part C responsive curricula. Provide financial support for development activities with TECTA in an initial phase of reform and adjust the support in subsequent funding cycles.
    d. Provide financial support to CCR&R Inclusion Specialists who provide technical assistance to keep children in typical settings, particularly community day care services. Use partnership to enhance public awareness about TEIS among the state's child care providers. Adjust the support in subsequent funding cycles.
    e. Incorporate Early Intervention services into the nascent Higher Education PreK/K degree programs which lead to professional licensure.

15. Commit state-level resources to training and credentialing care givers. Models to consider include:
    a. Long term partnerships with TECTA to structure and provide curricula developed in conjunction with OEC for both entry level training and ongoing workforce development.
    b. Developing curricula and a structure for training using expertise within the state system.
    c. Partnering with CCR&R to structure and provide curricula developed in conjunction with OEC.
    d. Providing self study; web-based training with pre-and post-test capacities; peer to peer mentoring; and statewide training workshops.
    e. Developing Interagency Agreements for cross training Service Coordinators, CSS Care Coordinators and DMRS staff in an Interagency Coordination Institute upon hiring and annually.
    f. Employ a combination of the above.
16. Incorporate the following into appropriate policies and contract requirements:
    a. Orientation and training will be within the scope of employment.
    b. Eligibility Determination and Service Coordination Managers will be responsible for orientation and training of Developmental Specialists and Service Coordinators in program philosophy, specific performance requirements, and state and local requirements.
    c. Providers who are vendors or who contract with TEIS will demonstrate/verify capacity in core competencies.
    d. All care-givers will participate in documented annual training updates and continuing competency credits.

Estimated Costs:

Training Coordinator (1FTE)	$81,000
Trainer/Mentors (3 FTEs)	$224,220
Training Events/Annual Conference	$45,000
TECTA Development	$25,000
CCR&R Inclusion	$55,000

DIRECT SERVICES

Background

Key Informants and Stakeholders considered issues and Best Practices to improve compliance with Part C Natural Environments requirements; criteria for group settings as Natural Environments; clinical integrity; the concept of Core Providers to be principally responsible for delivery of direct services; flexibility and funding of consultative therapy approaches for direct services; and services for children at age three who exit from Part C without referrals.

Findings

A tenet of Part C is for services to occur in Natural Environments, that is, in locations and in synch with normal daily living patterns of family and child. At their most pure, Early Intervention services are integrated into every aspect of a family's daily life,

- inclusive of families in which a parent or principle care giver is in the home for the most part, or

- in which a child is enrolled in day care as a typical peer might be enrolled, or
- in an inclusive community program in which children with delays are included in curricula with typically developing peers.

Natural Environments do not include clinical settings unless specialized equipment is a prerequisite for optimal services.

Tennessee serves 76% of children in a setting that is deemed a Natural Environment. When compared to the national average, improvement is still needed. However, Tennessee has seen continued improvement in the past few years, and during FY2005-2006, the State exceeded the targets agreed upon by OSEP by 2.5%. The range of compliance with settings in Natural Environments by Districts is from a high of 87% to a low of 56%, information which helps to focus where greatest improvement is needed.

Primary Setting % National Average	**State Total**	**District**								
		FT	**ET**	**SE**	**UC**	**GN**	**SC**	**NW**	**SW**	**MD**
Combined: Home and Community 87%	76%	84%	56%	71%	76%	87%	71%	80%	76%	85%

Tennessee is a medically underserved state. It is incumbent upon the State to expand its resource base with consultative approaches to direct services, educate families about accessing services, locate Service Coordinators visibly in county/local venues in order to build relationships, collaborate with other state services, assure best possible deployment of resources and identify service needs. The state can develop clear guidelines for consultative approaches that will extend the skills of therapists to more programs and to families. Overcoming the cost issue of consultation vs. direct therapy and safety factors are variables to be considered. Professional liability in consultative approaches is a moot point as therapists are training the family or other care givers to work skillfully with the child, which is within the scope of practice.

Demographic information indicates the most visible gap in services is for families and children

- served by TEIS who achieve IFSP goals prior to age three.
- who are ineligible for Part B Special Education services when they exit TEIS at age three; or
- who are not assessed for Part B eligibility and leave TEIS services without referrals.

The State chooses not to characterize these children as “At Risk.” However, the concern is that a success of TEIS, a child who improves functioning closer to a typical peer but who still experiences delays, will regress prior to entering a Pre-K program, a result of gaps in the system. The federal law permits Early Intervention services through age five, but only for children who, at age three, would be eligible for Local Education Agency (LEA) Part B Special Education programs. The State is in a position to provide a program to sustain children in Early Intervention services, without the requirements of Parts C or B, from the age three until entry into Pre-K programs.

Best Practices

Natural Environments:

The National Association on Education of Young Children (NAEYC) does not represent one

form of care and education for infants through age two as inherently better than another. However, the IDEA Infant and Toddlers Coordinators Association approved a position paper on Natural Environments with a set of principles that characterize successful early intervention in Natural Environments, the relevant federal requirements, and additional statements from OSEP. The Association fully supports the provision of Early Intervention services within the context of families' activities and routines in meeting the Natural Environments requirements of Part C. OSEP's direction stated services in Natural Environments support the natural flow of a family's activities; are delivered where the child lives, learns and plays; decreases a family's marginalization; uses natural supports; and builds on existing capacity of the community.

Acknowledging that most of the early intervention literature on implementation of Natural Environments is not empirically based, still researchers at Boyer Children's clinic in Seattle concluded from an extensive review of the literature that the naturalistic learning opportunities, authentic and developmentally-appropriate activities, and healthy parent-child relationships contribute to better developmental outcomes for infants and toddlers with disabilities.

Core Providers for TEIS include TIPS, DMRS, CSS and private providers. All are high quality. Service providers are not evenly distributed statewide, though, suggesting that the State look at the availability and accessibility of services when forming overall system plans. TIPS Parent Advisor Early Interventionists, who are part-time staff, are particularly important for achieving access to services in rural areas. DMRS services which are provided through contract agencies will be well positioned to extend services in Natural Environments when rates are restructured as a function of this Analysis, as will private providers. Following reform of the system, the State will be better positioned to know the extent to which there is excess capacity and where access to direct services is limited. Implementation of consultative approaches to direct services is a key.

Exploring Consultative approaches to Direct Services is important due to unwillingness of most therapists to change from clinic-based services to provision of services in Natural Environments. Expansion of Consultative models for Direct Services in Tennessee can incorporate these Best Practice criteria derived from work done in Connecticut. The requirements include

- Clear leadership and coordination structure.
- Specificity in regulations about frequency, duration and outcomes of consultation.
- Centralized database of consultants.
- Standard training curricula within and across disciplines.
- Regular training and networking activities for consultants within and across disciplines.
- Program managers in centers ready to receive consultation.
- Fiscal resources to support networks.
- Public accountability to child and system results.

Recommendations for Direct Services

17. Develop and implement a state defined Early Intervention program for children who drop out of service at age three who are not eligible for Part B programs.
    a. Structure the State program to sustain and improve the child's skills through provision of developmental therapy and/or other specific appropriate services.
    b. Include families in decision-making about services to be continued and by whom.
    c. Bridge families' experiences from Part C services through a home-based model focused on transitioning the child to school-based services at age four.
    d. Sustain Payor of Last Resort criteria of Part C to the state defined program to assure most efficient use of state and federal resources.

18. Maintain the current criteria for characterizing services delivered in Natural Environments as (1) in the home or other locations where families interact and (2) inclusive community programs licensed by DMRS or DHS.
19. Distinguish between group child care service and agency based interventions for Part C services aligned with the following:
    a. In group or agency settings, Part C services are those for which there are measurable goals and action steps in an IFSP. In group or agency-based settings interventions may be one-on-one instruction or as part of a group, as appropriate to develop the desired behavior. For example, motor skills development may be provided one-on-one whereas language training might be a part of a group exercise in which each child takes a turn.
    b. Parents are instructed in the methods used to generalize the skill training provided in the group setting to the home.
    c. Curricula are age appropriate for typical children and adjusted only when appropriate for children with delays is valid.
    d. Group settings in which a child was being served before TEIS involvement. Removing a child from that setting to receive Part C related services is strongly discouraged.
    e. Child Care Services are those provided in group or agency settings which are ancillary to the interventions in the IFSP. Child Care Services are not required and are not paid by TEIS. Child Care Services may be paid by families, Families First, grants or other sources available to the program.
20. Define inclusive settings as those in which the majority of children are typically developed for their age. Abandon the requirement for adherence to 50/50 ratio of typical children to children with delay in group settings.
21. Establish a protocol to guide procurement of services from Core Providers in order to assure a proper sequencing for System of Payments requirements.
22. Expand use of the consultative approach for provision of direct services. Incorporate the criteria for Best Practices noted above. Implement these processes to promote consultative approaches in each District:
    a. Identify consultants to provide information, education, modeling opportunities to other therapists.
    b. Provide financial incentives to stimulate greater application of consultative approaches.
    c. Replicate/expand the approach in which TEIS funds therapist FTEs in provider agencies with the agreement that the agency will seek all possible reimbursement and return that revenue to the contract. Ensure documentation of denials by other fund sources and appeals before using Part C dollars.
    d. Provide state seed money to initiate/expand the consultative approach by agencies that want to provide services in Natural Environments.
    e. As the consultative model takes hold, restrict clinic-based services to only exceptional circumstances in which appropriate appliances and supports are available only in clinics.
23. Support expansion of programs with fidelity to a research-based model of family-to-family peer support and other research that will add to the cadre of best practices in family services.

Estimated Costs

State Early Intervention Program	$2.4M
Consultative Models for Direct Services	
Northwest & Greater Nashville	$44,000
South Central	$75,000

Background
Key Informants and Stakeholders considered Best Practices about relationships between Part C and Part B federal requirements; policy guidance delineating responsibilities of TEIS Service Coordinators and LEAs; timelines for transition and development of Individualized Education Programs (IEPs); constraints imposed by funding limitations in LEAs; and difficulties experienced by families in transitioning from one program to the other, among other considerations.

Findings
At age three, children who are eligible enter LEA Part B Special Education programs. There are some limited accommodations being made for children who turn three years of age by 4/31 who are no longer eligible for Part C services, but more could be done to ease transition of children from Part C to Part B programs without a break in service. Better coordination between District Administrators and LEAs is needed. DMRS programs have tried to accommodate as many families as possible by transferring children to DMRS funded services when TEIS eligibility is exhausted prior to entering Part B programs.

It is incumbent upon the OEC to formulate strategies to make the transition from Part C to Part B as coordinated as possible so as to minimize the differences between the two programs. Thirty seven percent—1257 of 3436 children who exited from Part C in CY06—transitioned into Part B services. This falls below the national average of 42% who enter Part B programs. Parents indicate that transition from one program to another is exceedingly complicated, fraught with miscommunication, and with extended periods of time between a child's birthday and implementation of IEPs. Even when an IEP is developed for a child before age 3, it is a too common practice to delay implementation of the Plan until August. Of equally great concern is that Part B eligibility was not determined for 21% of children leaving TEIS.

Best Practices
Indiana's State Transition Initiative for Young Children and Families was established to assist in creating a comprehensive community-wide system ensuring positive and effective transition experiences. Transition Teams develop, coordinate, and implement transition activities within their communities; build upon existing structures within their communities; provide training to enhance effective transition teams; provide on-going technical assistance; provide Transition Facilitators to conduct meetings; provide evaluations of Memorandum of Agreements and/or drafts of MOA's; provide assistance in writing Transition Grants; and provide assistance in planning a local transition activity, meeting, and/or training.

The following are examples of best practices occurring to a very limited extent in the State:

- Early Intervention coordinators contract with school systems before the child's third birthday to have LEA provide Early Intervention services when appropriate – usually when child is identified close to three years of age, or when a child needs intensive services as for autism—to provide IFSP services, not free appropriate public education (FAPE).
- LEAs designate transition coordinators.
- Early Intervention specialists and LEAs use similar tools for evaluation and share information.
- TEIS and LEAs collaborate to provide comprehensive joint Child Find activities.

- LEAs hold group parent information meetings, or preschool parent collaborative meetings, before transition meetings to introduce parents to the schools and answer general questions.
- Some LEAs provide abbreviated summer services for all preschool children.
- Schedules of some preschool staff are staggered to cover summer sessions or LEAs use other means of service provision in the summer, such as continued TennCare services, or paying the co-pay for private insurance.

Recommendations to maximize the relationship of Part C and Part B Services

24. Establish and convene a group of policy level administrator decision-makers representative of Part C and Part B programs and charge them with the responsibility to develop comprehensive strategies to identify and resolve the issues of transition from Part C to Part B programs. Include these constructs:
    a. Establish clear lines of communication and accountability between Part C Service Coordinators and LEAs.
    b. Determine the reasons Part B eligibility is not being determined in each District and implement strategies to improve that.
    c. Establish quantifiable indicators of seamless transitions, including experiences of families. Identify Districts and LEAs with best transition performance to use as models for areas with lesser performance.
    d. Clarify each system's rules and regulations, particularly Least Restrictive Environment and requirements for children turning three in the summer.
    e. Determine the extent to which different evaluation processes, requirements and tools may impede transition and reconcile the differences within the context of applicable laws.
    f. Use Estimated Prevalence data from this Analysis to help focus District level plans and solutions.
    g. Enlist MCOs to provide transitional case management of TennCare enrolled families leaving TEIS and due to start Part B programs.
    h. Review transition performance periodically and adjust strategies as needed.
    i. Provide annual reports of performance to coincide with Special Education conferences. Include representatives of TEIS Districts in conferences.
    j. Publicize and celebrate improved transition performance.
25. Co-locate some TEIS service coordinators at LEA locations to build relationships, provide meeting space for families, share materials, clerical support, and space, and to be visible in partnership with the LEA in the community.
26. Provide guidance for IEP teams to make decisions based on the needs of the child, and not the configuration of offerings in the LEA.
27. Educate parents and other care givers about the differences in the two systems of delivery when families exit from Part C services.
28. Minimize credentialing and supervision differences between Part C and Part B to the extent possible.
29. Request guidance from OSEP regarding expectations for services for children who transition in the late spring and summer. Develop state policy which conforms to OSEP guidance to be implemented at the local level.
30. Clarify in multi-district counties with parent choice of LEA, which LEA has legal responsibility for child.

Estimated Costs: Cost Neutral

Background
Key Informants and Stakeholders considered Best Practices to increase and cultivate Family representation; representation of Local ICCs at the SICC; the relationship of the SICC purposes, structure and processes to Early Childhood Comprehensive Systems (ECCS) planning; mechanisms to increase coordination of services, and visibility of children's issues.

Findings
The Statewide and Local Interagency Coordinating Councils (ICCs) have evolved to different levels of performance. Establishing clear roles and responsibilities for the SICC and LICCs will strengthen communication about system issues and permit the Councils to perform more viable functions than they currently do. ICC leadership is due credit for making participation easier, like holding SICC meetings at different locations throughout the state. However, professionals who are able to meet during the day dominate participation and family participation is often minimal. Generally, accurate perceptions are that the Councils are useful for keeping up with policy clarifications, "show and tell" opportunities about programs, and making connections, but not for planning nor advisory purposes.

The SICC and LICC purposes and structures need to be reviewed periodically and consensus gained about appropriate functions for the Councils. The relationship of the ICCs and other planning groups to ECCS need to be clarified. Consideration must be given to approaches to increase participation by videoconferencing, meeting at times convenient to families and other uses of technology.

Best Practices
Best Practice criteria for Interagency Planning can be modeled after work done in Washington's Kids Matter Plan:

- Approach early childhood systems as a collaborative effort.
- Serve as an over-arching bridge for comprehensive and integrated frameworks.
- Define common goals and outcomes.
- Outline specific strategies and partners.
- Focus on accountability and evaluation of progress.

Additional criteria logically include active participation by all Stakeholders, especially families, and responsiveness from the Lead Agency to Interagency-formed plans.

Recommendations to Strengthen Interagency Planning
31. Establish in policy the following purposes of the Statewide Interagency Planning Council:
    a. Advise the State and assist in the development and implementation of relevant policy.
    b. Disseminate information about state, district/local and program matters.
    c. Assess consistency and uniformity among districts and make recommendations to achieve consistency.
    d. Make availability of services known to the public.
32. Structure the SICC as follows:
    a. Each LICC shall be represented at the SICC, although not necessarily as a Council member.
    b. For each ICC member there shall be an immediate alternate to assure appropriate diversity and participation.

c. Family representation shall be increased and cultivated.
d. DOE/OEC shall pose a policy issue for input for each SICC meeting, to the extent possible.
e. Documentation shall reflect actions taken by the SICC.

33. Incorporate the following processes into the activities of the SICC:
    a. Develop Council by-laws.
    b. Develop a simplified Annual Report to be used for general communication, public awareness and as a report to Legislators and others.
    c. Develop an orientation to the Council for new SICC members, especially family representatives. Considerations include recruitment; preparing parents for participation; identifying alternate parent members to assure availability; mentoring from seasoned Council members and informal settings for meetings.
34. Create and maintain a joint training calendar among the child serving agencies.
35. Participate in and contribute appropriate program and financial information to ECCS.

Estimated Costs:

Staff Support	$7,000
Travel, training for parents	$10,000

Part II. Administrative System Concepts and Recommendations

ACCOUNTABILITY FOR RESOURCES

Background

State-level administrators and Stakeholders considered Best Practices to achieve a level of accountability that would meet the State's standards overall and satisfy OSEP's Payor of Last Resort requirements; effective controls over program budgets; accountability for contract and sub-contract compliance; protection of existing state appropriations system wide; possible efficiencies in joint monitoring, and how to prompt administrative consolidation among the major program areas, among other matters.

Findings

DOE, the designated Lead Agency for Part C, is responsible for coordination of Part C services and accountable for federal funds and state appropriations in the system. Within the Division of Special Education, OEC is responsible for overall management of TEIS. The Office receives routine administrative support for budget, contract management, and human resources. Additionally some of the functions and costs of OEC are supported with Part B funds. Notwithstanding the integrity of OEC, the infrastructure has been insufficient to discharge the administrative responsibilities effectively, evidenced by ongoing negotiations with OSEP about fiscal assurances. OSEP only recently lifted the conditional status from TEIS' federal funding after the parties came to terms about the State's System of Payment policies. Among the issues has been that TEIS pays for services that it ought not, when other fund sources are available. Insufficient control of the payment system is attributable in part to administration of the system through nine district level contracts. Review of some transactions of the 700+ subcontractors statewide indicated that some Districts do not fully conform to State policies, a significant issue of accountability for resources.

It is also a concern that budget overruns occurred in three consecutive fiscal years due to little control over some programs. Mid-year improvements were granted, yet there were no concomitant increases in direct services. A policy directive to utilize DMRS services before making referrals to DOE programs, specifically TIPS, had unanticipated consequences, one of which was that POEs asked DMRS contract agencies to increase service capacity, thus continuing expenditures at much the same level as that prior to implementation of the policy directive.

The administrative relationship between DOE and DMRS, now a strong one, was established by fiat when TEIS was initiated. Commitment to families and quality services, plus strong professional relationships, permit the two departments to function together well. OEC annually transfers over $880,000 of the $7.9M federal Part C dollars to DMRS with which DMRS contracts for Early Intervention services. However, TEIS alone bore budget cuts when they were necessary in prior years, so it was startling to DMRS providers when budget reductions were spread proportionately including them for FY07, creating some instability in the system. Some DMRS providers are funded through contracts with both DMRS and TEIS, which is administratively cumbersome for the providers. DMRS services are notably well administered, showing well in the quality assurance program, Continuous Improvement Monitoring Program (CIMP), and keeping overall administrative costs to about 22% of total budget. Concern has been expressed, however, about long term availability of DMRS appropriations for Early Intervention services because the designated amount is pooled with adult services dollars and that only one FTE administrator is responsible for contract management, quality assurance and technical assistance as well as other duties not associated with Early Intervention services.

The problems noted above did not occur suddenly but have been building for some time. The Part C Financial Task Force completed its work with a number of well conceived recommendations which would have strengthened accountability for resources, but the recommendations were not implemented.

Best Practices

Other states have developed Central Reimbursement Offices (CROs) to capture all payment sources to the greatest extent possible and sequenced to assure compliance with Payor of Last Resort requirements of Part C. Indiana has the most mature model: The CRO pays service providers from a revolving fund as bills are submitted, then bills the appropriate state agency for reimbursement. It satisfies all reporting requirements to the state funding sources based on interagency agreements. Information is obtained from families to establish the services for which they are eligible and available fund sources. Tennessee is not prepared to implement that structure coincidental with recommendations to reform the system, but the State is positioned to centralize contract functions as a first step toward establishing a CRO. Prerequisites for successful CROs include well established financial relationships, particularly with TennCare and private insurers.

Central contracting and/or establishing Vendor Agreements permit the State to assure compliance with state requirements, monitor service volume and couple financial information more easily with TEIDS data. [Reform Document 9]

Recommendations to Assure Accountability for Resources

36. Centralize contracting in DOE Administration.
    a. Consolidate billing functions within the existing DOE administration systems.
    b. Increase by four FTEs the number of billing staff to accommodate the volume of work.
    c. Align contract Scope of Services to conform to the new system.

d. Specify responsibilities of Districts to develop and maintain good provider relations at the local level.

37. Establish Vendor Agreements in lieu of contracts where appropriate. [Reform Document 9]
38. Establish Data Management and Federal reporting function and position in OEC to assure better integration of program and financial management information.

Estimated Costs: $250,000
Estimated Cost Savings: $526,710

ADMINISTRATION OF THE SYSTEM

Background
Key Informants and Stakeholders considered Best Practices about the system that are larger than that of accountability alone: benefits and limitations of the current service organization, locations of POEs and funding structures; optimal organization of Eligibility Determination, Service Coordination/Targeted Case Management administration and supervision; approaches to gain consistency in policies, practices and funding of District level administration; review of data related to the 45 Day Timeline requirements by District; budget accountability; timely payments; role of DMRS Regional Offices in local administration; the need to enhance Training and Workforce Development; and roles of the PIs and Project Coordinators, among other matters.

Findings
A thorough analysis of all aspects of administration reveal duplication in the number, functions, and type of administrative personnel, coupled with insufficient administrative visibility for some functions—particularly Public Awareness and Child Find, Training and Technical Assistance—and actual locations of POEs. In addition, an excessive amount of supervision contributes to high administrative costs.

District TEIS Point of Entry Offices and Roles of Principle Investigators (PIs). Current contracts with the nine District POE offices vary widely and are an outgrowth of early funding decisions, the criteria for which have long been abandoned. Inconsistencies are exacerbated by the administration of the contracts in eight different academic settings and one community hospital, all with varying salary and benefits policies, administrative costs above those identified in contract line items, and numerous idiosyncrasies. POEs were originally located in academic settings because at inception of the Part C program, Early Intervention services were nascent and described as “investigational.” The services are no longer considered investigational. Subsequently, research funded by TEIS in the academic settings has been defined at the discretion of the PIs and has not necessarily benefited the Early Intervention system. At the same time, the PIs are considered an under-utilized resource in the areas of Early Intervention curricula development, Early Intervention focused research and best practice guidance.

PIs have assumed different levels of hands-on responsibility for administrative oversight of the offices; salaries and benefits are controlled by the universities or hospital; invoice processing, data management and subcontract process vary; and at its inception, some statewide services such as Public Awareness and Training were lodged in different local contracts. Among the supports provided to POEs are information technology, space, graphics, small conference areas and other in-kind services. It is said that affiliation with university settings adds credibility to

TEIS and avoids conflict of interest. Additionally, some of the POEs have access to practicum students and the research they do related to Early Intervention; some medical school interns spend on site time with service coordinators on the job; and there are educational opportunities for service coordinators in some academic settings.

The research model established 21 years ago is no longer appropriate and is too costly for the contemporary service delivery system. Analysis of POE resources suggests that 8% administrative fees paid to POEs is in addition to line item allowances for administrative costs. Over $2.3M is associated with administrative personnel and functions, plus $1.3M is paid in indirect costs in the 9 TEIS POEs. Only $7M of the POE's total budget of $17.2M is spent on direct IFSP services. High costs are attributable in part to location of POE Offices in academic settings and historic variations in foci other than services. The POEs are not visible in the community. While it is true that the principle services provided by POEs—Eligibility Determination, Service Coordination, and IFSP development—occur in Natural Environments, not the offices themselves, the service is functionally invisible to the public at large so self referral for Child Find is difficult.

Administration of TEIS and TIPS. Administration of TEIS and TIPS are confounded by redundancy in administrative and service roles. A thorough review of functions and self report in the two areas reveal duplication of effort. Currently there are a total of 110 Full Time Equivalent personnel in the POEs, TIPS, and Lead Agency state-level administrators statewide. Administrative personnel costs are high.

- Over 38%—$10M—of the $26.1M in TEIS and TIPS, attributable in part to duplication of similar functions in the two areas and excessive supervision in TIPS.
- Over 54%—$5M—of the $9.3M in TIPS, leaving $4.3M for direct services.

Administration costs in TIPS are attributable to an erroneous characterization of the program as a State Special School. The State has funded TIPS positions and salaries according to some but not all of the provisions of DOE policy guidance for State Special Schools. The record includes draft memoranda and minutes from meetings prior to establishing an initial 13 state positions for TIPS administration. One memorandum approved by the Commissioner of Education at the time includes the TCA citation for salaries of teachers in special schools. However, there is no legal authority establishing TIPS as a special school. TIPS is a valuable DOE program, committed to strengthening families and reaching well into rural areas of the state. But it is a misnomer to refer to the program as a State Special School and it is not appropriate to administer it as such. Rather it is a program within the formal organization of DOE Early Childhood Programs.

Time Surveys done as a part of the Financial component of the Analysis validate the duplication of effort between TEIS and TIPS personnel. When considered in the context of the specific roles and responsibilities, duplication of effort occurs in processing referrals; completing family needs assessments; developing IFSPs; participating in initial, six month review and annual IFSP and transition meetings; and monitoring service delivery through data review, among other processes. TIPS' training and mentoring functions are important for sustaining quality services. Data indicate that of the 600 part time positions, in any given month, 325-350 Parent Advisors are actively delivering services. The high level of supervision—35 state staffed Regional Lead Teachers (RLTs) plus eight additional contract RLTs—results in a ratio of 1 RLT: 8.4 active part time staff, all of whom are degreed teachers. There are costs associated with maintaining excess capacity and with excessively high levels of supervision. Another inefficiency revealed through the analysis is that TIPS has historically provided only one of the 16 required services of IDEA Part C whereas TEIS has the responsibility of all Part C required services.

Best Practices

The Analysis provided a rare opportunity to sequence reformation of a system properly, that is, by first asking questions about a desired Service System, followed by how best to administer the system; and last, determining the finance strategies that will stabilize and strengthen the system, near- and long-term. In this paradigm, services drive the resources and not the reverse.

Those questions were answered in the context of the Principles for the analysis. Best practice for Tennessee is a new administrative model based upon reform of two fundamental functions: (1) Eligibility Determination processes and (2) development of functional, family-focused Individualized Family Service Plans. The new model accommodates training and mentoring of service providers statewide; clarifies Child Find and Public Awareness policy development and programs; establishes data management at the state level in OEC. Much of the best practice considerations are noted above in the areas of Eligibility Determination, Service Coordination and IFSP Development and in Child Find, Public Awareness and Direct Services.

Recommendations for Administration of the System

39. Unify the Service System, principally TEIS, TIPS and EI services of DMRS. Reduce from 110 to 54 the number of Administrative FTEs.
    a. Restructure District Administration based upon streamlined Eligibility Determination processes, enhanced Service Coordination capacity and routines based family assessments in developing IFSPs.
        i. Require consistent statewide accountable, organizational structures in the nine Districts.
        ii. Establish 9 FTE state positions for District Administrators responsible for district leadership, budget accountability, provider relations/recruitment, Human Resource management, quality assurance, data management and oversight and overall supervision of Eligibility Determination, Service Coordination and Direct Services.
        iii. Establish 9 FTE state positions, one per District, for each of these functions:
        ….Eligibility Coordinator responsible for coordinating Child Find activities; procuring and maintaining medical information in support of eligibility assessments; coordinating process for medical diagnosis/condition outliers; providing relevant areas of training in core competencies of Developmental Specialists.
        ….Service Coordination Manager responsible for assigning families to Service Coordinators; referring families to Eligibility Coordinators; managing protocols for referrals to providers; oversight of IFSP content quality; administrative functions of hiring, performance evaluations, and compliance with Targeted Case Management requirements; filling in as needed in serving families; and coordinating assessment of families' satisfaction with services.
        ….Direct Services Coordinator responsible for assuring documentation of appropriate core competencies of all providers; coordination of other training and mentoring with state level Training and Workforce Development priorities; coordination of CIMP; compilation of management information reports; and other related administrative duties, including direct supervision of TIPS early interventionists and compliance of contractors and vendors with terms of those agreements.
40. Establish 129 FTE state positions, distributed throughout the Districts statewide at a ratio of 1 Service Coordinator for every 40 families, responsible for intake processes, gaining family consent and establishing dates for initial IFSP team meetings; performing routines-based family assessments; informing and educating families about service options; convening and

leading IFSP meetings of family members, Developments Specialists and provider/Early Interventionist, if known; documenting processes timely. House Service Coordinators in state or county education or health department offices and require on-site presence in those locations except when performance of one's duties contraindicate. Restrict use of the term Service Coordination and funding for that service to only staff of TEIS.

41. Establish 23 FTE state positions, distributed throughout the Districts Statewide based on the number of assessments typically done, at a ratio of 1 Developmental Specialist sufficient to perform 8-10 post-referral screening and ED assessments per week inclusive of documentation and IFSP meeting participation and periodic Ongoing Early Childhood Outcome evaluations required for OSEP compliance.
42. Establish 9 FTE state positions, one per District for each of these functions:
    a. Data Management
    b. Administrative Support.
43. Increase the visibility of POE Offices. Relocate the offices in the community, co-located in District Education Offices, LEA Education or Special Education Offices, or County Health Departments.
44. Establish a TEIS Advisory Consortium with identifiable resources for a Division of Special Education focused research agenda that benefits TEIS and to assist with policy development, development of EI training curricula, informational support for low incidence disabilities, special projects and grant proposals. Augment the current PIs' expertise with other desired expertise, especially workforce development and guidance in Assistive Technology Guidelines for Hearing Devices. The identified resources will be clearly linked to deliverables. Retain PIs' relationships with the Districts in which they currently serve in order to assure contribution of institutional memory for the District and continued familiarity of system issues for PIs in their new role.
45. Shift contracted functions for Training, Public Awareness, and Data Management and Federal Reporting from POEs to Office of Early Childhood. Designate grant monies to the Advisory Consortium to be available for state guided Technical Assistance, Printing and publication, and Data Management support functions.
46. Restructure State level administration to support the delivery of quality direct services at the District level.
    a. Establish for each of the following functions in OEC:
        i. Public Awareness and Child Find Coordinator: one FTE to develop and implement a comprehensive, cohesive market-based approach to Public Awareness, providing strong organizational, marketing, communication, analytical and leadership skills, and facile with estimated prevalence and other relevant data so as to tailor Child Find Strategies to targeted counties with the greatest growth to accomplish.
        ii. Training and Workforce Development: one FTE Coordinator and a team of three FTE Trainer/Mentors. The Coordinator is responsible for developing, coordinating and maintaining a comprehensive Workforce Development plan in collaboration with CCR&Rs, TECTA, District Administration teams, the Advisory Consortium and CSS. The Trainer/Mentor Team is responsible for organizing and implementing approaches to assure periodic review of individuals' skill performance in providing developmental therapy, family support services and compliance with other quality standards. The Team works collaboratively with District Service Coordinators and others to assure timely, efficient deployment of resources.
        iii. Direct Services Coordinator: one FTE responsible for policies and procedures to assure consistency in direct service models; oversight of Developmental Therapy services in particular; coordinate provision of direct services with DOH Maternal and Child Health, CSS, HUGS and CHAD; facilitate and track technical assistance to contracted core providers and approved vendors; coordinate district level vendor communication meetings.

iv. Establish one FTE for OEC Data Coordination to better manage and integrate TEIDS, financial and other information in support of policy development.

b. Establish Central Contracting capacity in DOE Administrative Services. Reference 36 above.

47. Shift EI resources in DMRS to the Lead Agency as a mechanism to streamline administration and assure long term availability of those resources for EI services.
48. Establish the Advisory Consortium to conform to 44 above, adding expertise as needed to permit best practices and state of the art input into the system.
49. Establish an Interagency Agreement with CSS setting out the terms under which the CSS and the Director of MCH will participate in the eligibility determination process for families of children whose diagnoses are not on the State Authorized List but whose condition will likely result in developmental delay without intervention services.

Estimated Cost Savings		$5.7M
Estimated Costs	Advisory Consortium	$252,000
	Deliverables including	$ 90,000
	Research Opportunities	
	Curriculum Development	
	Training	
	Quality Assurance	
	Data Management Support	$35,000
	Technical Assistance Grant	$50,000
	TRIAD($305,000)	Cost Neutral
	State level administration	$1.4M
	District level administration	$2.2M

FUND EXPANSION ACTIVITIES

Background

The intent of this Analysis has not been to make a case for new appropriations for TEIS. Tennessee is described as well-funded when compared to other states. Rather the intent, and the outcome, has been to have such thorough knowledge about resources in the system so as to deploy them as effectively and efficiently as possible. Fund Expansion Activities identify new sources of revenue, opportunities to leverage additional dollars or expand service support through collaborative relationships. Emerald Consulting focuses on two approaches to resource expansion:

- Accessing other resources through a variety of options which can support various components of the Part C system infrastructure, and
- Accessing resources, supports and services through other agencies and programs at the Federal, State and local levels that have an existing, specific and defined responsibility or interest in the Part C target population.

The Fund Expansions planned in reforming TEIS include

- Leveraging Federal Medicaid dollars for Developmental Therapy with a portion of current State appropriations.
- Establishing base rates and enhanced rates for services delivered in Natural Environments.
- Utilizing an existing process in CSS and MCH, as a consultant in Eligibility Determination for children whose medical conditions are not on the State Authorized List for TEIS.

- Complementing CSS, TennCare, and private resources with TEIS dollars to procure highest quality assistive technology when warranted.
- Collaborating with TECTA and CCR&R agencies in developing and implanting Core Competencies curricula.
- Developing Interagency Agreements for cross training Service Coordinators, CSS Care Coordinators and DMRS staff in an Interagency Coordination Institute.

Findings
The Fund Expansion Activities of this Analysis are not complete and will continue during FY07.

Recommendations for Fund Expansion Activities
50. Complete the Financial Analysis in collaboration with Emerald Consulting to determine
    a. The availability of any additional federal sources of support which are not being drawn down appropriate to TEIS.
    b. Collaborations with other child serving agencies, particularly CHAD, HUGS, and other home-based services relative to training and service coordination.
    c. Elements to be considered in establishing Family Participation in the System of Payments, including policy development, equitable implementation and appeals processes and appropriate training for Service Coordinators.
    d. How best to incorporate Early Intervention services into SCHIP coverage.
    e. Approaches to gain mandated insurance coverage for Early Intervention services and to enforce a requirement for insurers to pay for Early Intervention services if they are available in the benefit package.
    f. Approaches for Public/Private partnerships particularly as they might apply to Assistive Technologies.
51. Plan for Central Billing in collaboration with TennCare, DOH, Finance & Administration, and Insurers as a method to assure TEIS as Payor of Last Resort as required by Part C Systems of Payment.
52. Determine if and how “Braiding” funding at the State level, which requires adoption of the most stringent standards of the funding sources involved, would benefit providers.

Estimated Costs: Consultation $12,000

GOVERNANCE

Background
Many states are grappling with Governance and organization of services for children, age birth to five years, in the contexts of School Readiness and planning activities funded by the Federal Early Childhood Comprehensive System grants awarded during the last three years. Nationwide, a variety of models are being explored, characterized by NECTAC as taking one of three approaches:

- Create a new Department or office that brings together early care and education programs and functions from other agencies (Massachusetts, Washington);
- Move some or all early care and education programs and functions from various agencies into an existing state agency (Georgia, Maryland); or

- Leave functions in different agencies and create a high level multi-agency early childhood management team with strong leadership and gubernatorial support to create unified policy and implementation.

Findings

Regardless of the model, the goals of these approaches appear uniformly to be improving the well-being of children and families; effective service coordination and provision of service before crises occur; enhanced information systems and communication; reducing silos of funding so that resources are more efficiently used at state and local levels; formation of children's budgets; and raising the visibility of an Early Childhood agenda and thus a priority on children.

In the earliest stages of the Analysis, the Commissioner of DOE put in play the question of DOE's continuing as the designated Lead Agency. Other states have designated Departments of Health, Workforce and Economic Development, and Children's Services or Governors' Offices as Lead Agencies. Concerns about DOE as the Lead Agency did not arise during listening and information gathering phases of the Analysis. It is clear that OEC has a good, well established relationship with OSEP that has been beneficial as the state has worked to resolve long standing compliance issues. The issue that has been raised, however, is the visibility of OEC within DOE and the relationship of OEC to the Office of Early Learning, responsible for Pre-K Programs. Promotion of School Readiness suggests a clear organizational relationship between the two areas, especially since coordination of Part B Preschool Special Education programs resides in OEC.

To be considered in the context above and Best Practices are

- purposes of a systematic review of systems and programs for children, birth to five years, and their families;
- benefits and limitations of organizational relationships of those systems;
- administrative strategies to integrate planning, services, information and maximize funding;
- costs and benefits of reorganizing system relationships.

Best Practices

Experience gleaned from this Analysis and processes of other states suggest that the following are important criteria for achieving consensus about organization of services for children, birth to age five, and their families:

- All parties agree that there are system improvements to be made.
- The context, purposes and scope of the exercise are clear. Several states have put such analyses in the context of School Readiness, inclusive of health and welfare services.
- Political realities are acknowledged but are not to be impenetrable obstacles if systems for families can be improved by changing the conditions.
- Stakeholders, in this case, State child serving departments, agencies and offices, commit to a timely process for concluding a systems review and dedicate resources for that purpose.
- There is no expectation for new resources to implement system changes, rather that existing resources will be maximized.
- There is expressed political will to implement system changes if it can be demonstrated that the changes will improve services to families.

Recommendations for Governance

53. The State's child serving agencies will agree to a thorough review of the systems of services for children, birth to five years, and their families with the intent to form recommendations to improve the collective systems.
54. DOE will review the organizational position of OEC within the Department relative to its visibility and content relationships. Place leadership of OEC in a position classification on par with peers who have a similar span of authority.
55. Revise the Interagency Agreement, extant, to conform with a reformed TEIS.

Estimated Costs: Cost Neutral

EVALUATION OF TEIS REFORM

Background

The objectives of the Analysis are met, with the proviso that there will be further attention to Fund Expansion opportunities. The Analysis includes

- A description of the current service system
- Articulation of service gaps, obstacles to service delivery, and areas of unnecessary duplication, including program administration, as well as system strengths;
- The amount available from all sources for services and program administration and recommend approaches to maximize the total, with more focus on this area continuing
- Incorporation of sound business practices for objectivity and accountability.
- Inclusion of research findings to help shape appropriate system reform.
- A set of recommendations to reform the system for immediate and long term stability and growth.

Findings

To be fully accountable for the consequences of reforming the system, Principle Investigators and Stakeholders identified five key performance measures which, if achieved, will indicate success of the reform:

- The number of children served compared with national rankings under the same conditions.
- The State complies with 45 Day Timeline requirement for development of IFSPs.
- Service Coordinators serve no more than 40 families.
- Relative to Early Childhood Outcome Indicators, when children exit from services, their development approximates that of typical peers.
- Expenditures do not exceed resources.

Performance measures required information currently available against which the system could be compared periodically. Clearly there are many more than the five performance indicators which can measure success—and shortcomings—of the reform. The Early Childhood Outcome Indicators will be particularly difficult to achieve near term because it is a relatively new requirement of OSEP and implementation is new in the State. The five indicators were selected because they represent performance expectations in areas which are fundamental to the reform and the administrative reorganization which evolved from service system priorities and for which there is current data.

Best Practice

Part C sets high standards for family and system evaluations. It requires peer reviewed research based services; a method of ongoing assessment of children's development with Early Childhood Outcome Indicators and Family Outcome Indicators. It serves the State well to

evaluate its own strategies to improve services to families by implementation of comprehensive recommendations to reform TEIS.

Recommendations to evaluate reform of TEIS

56. Evaluate the success of TEIS reform inclusive of these or more rigorous appropriate constructs:
    a. Establish baseline for the performance indicators listed above as of April 2007.
    b. Identify fundamental elements to implement the reform. Establish points at which identified elements of system reform are to be complete. Relate the performance indicators to the completed elements of implementation. Identify elements of continuing implementation and relate them to the performance indicators.
    c. Track the performance indicators at six month intervals beginning October 2007 and every six months thereafter until all reform elements are implemented.
    d. Report the results to DOE Leadership, ICCs and Stakeholders.
57. Adjust the course of implementation if the performance indicators do not reflect system improvements, allowing for a period of initial instability in the system.

Estimated Costs: Cost Neutral

SUMMARY

Since its inception in late 1986, when then Governor Alexander designated DOE the Lead Agency for TEIS, to date, the system has undergone many changes, the most recent being implementation of TEIDS, the information related data base which will set the standard for the nation when fully implemented. During these years the State has complied with of almost all of the requirements of the Part C program but it has fallen short in some of the most important ones like System of Payments. The State can also improve its provision of services in Natural Environments and develop more family-functional IFSPs. What have not changed during this period are Administration and funding of the System, except for increases in State support annually.

The 2006 Analysis, performed at the request of the Commissioner, opened windows into the history of TEIS and current practices. This, the first comprehensive review of TEIS, brought together more than 100 persons with diverse roles in the system, years of experience and expertise. The Analysis relied on information tailored to describe the unique characteristics of the state; best practices and models relevant to improving the service system as well as the strengths of the current system. The Analysis did not shy away from difficult questions and issues.

On that basis, the State can move forward with implementing the recommendations to reform TEIS, confident that the new model will achieve administrative efficiencies, assure the delivery of quality services, and permit services to be offered to additional families. The State will be able to build upon a new foundation for near- and long-term stability and growth, having gained a greater understanding of what the current system entails and with a path to the future of the system in hand.

TENNESSEE EARLY INTERVENTION SYSTEM

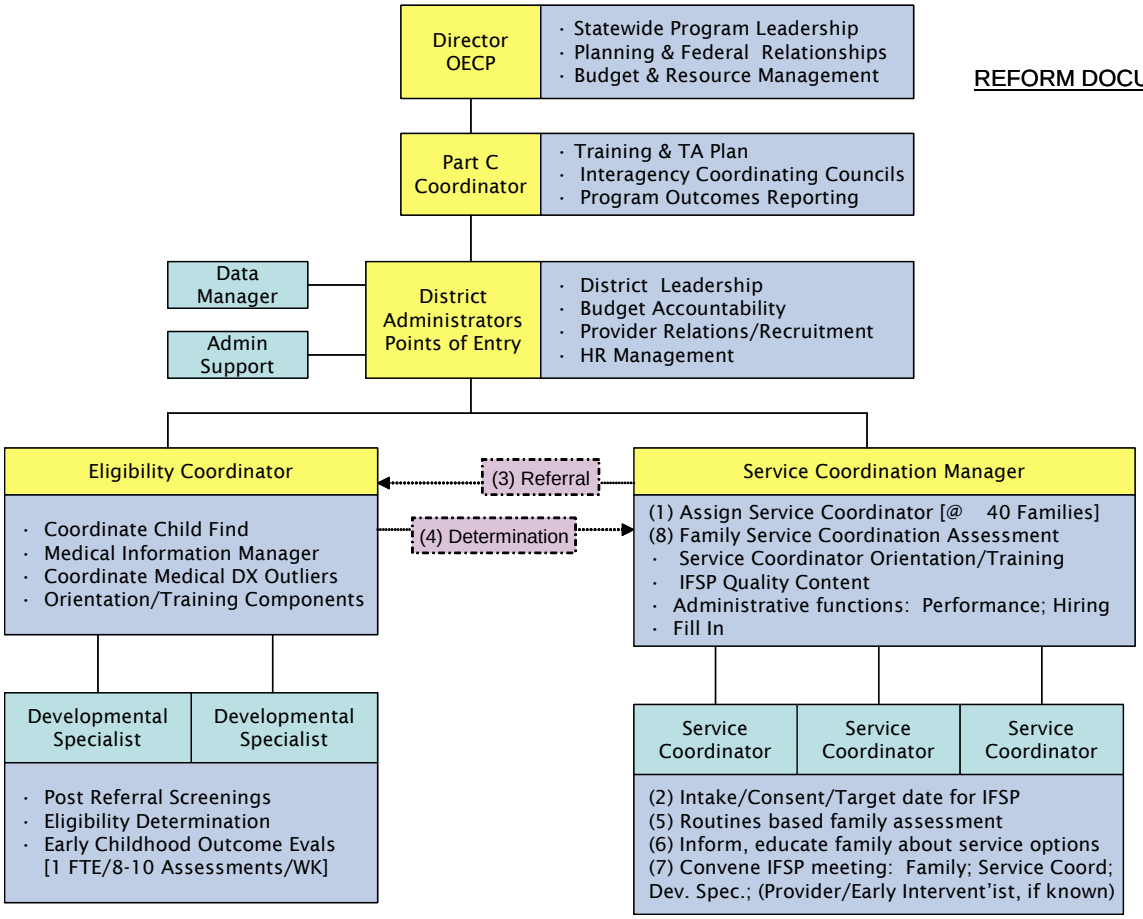
2006 Analysis Report and Recommendations

REFORM DOCUMENTS

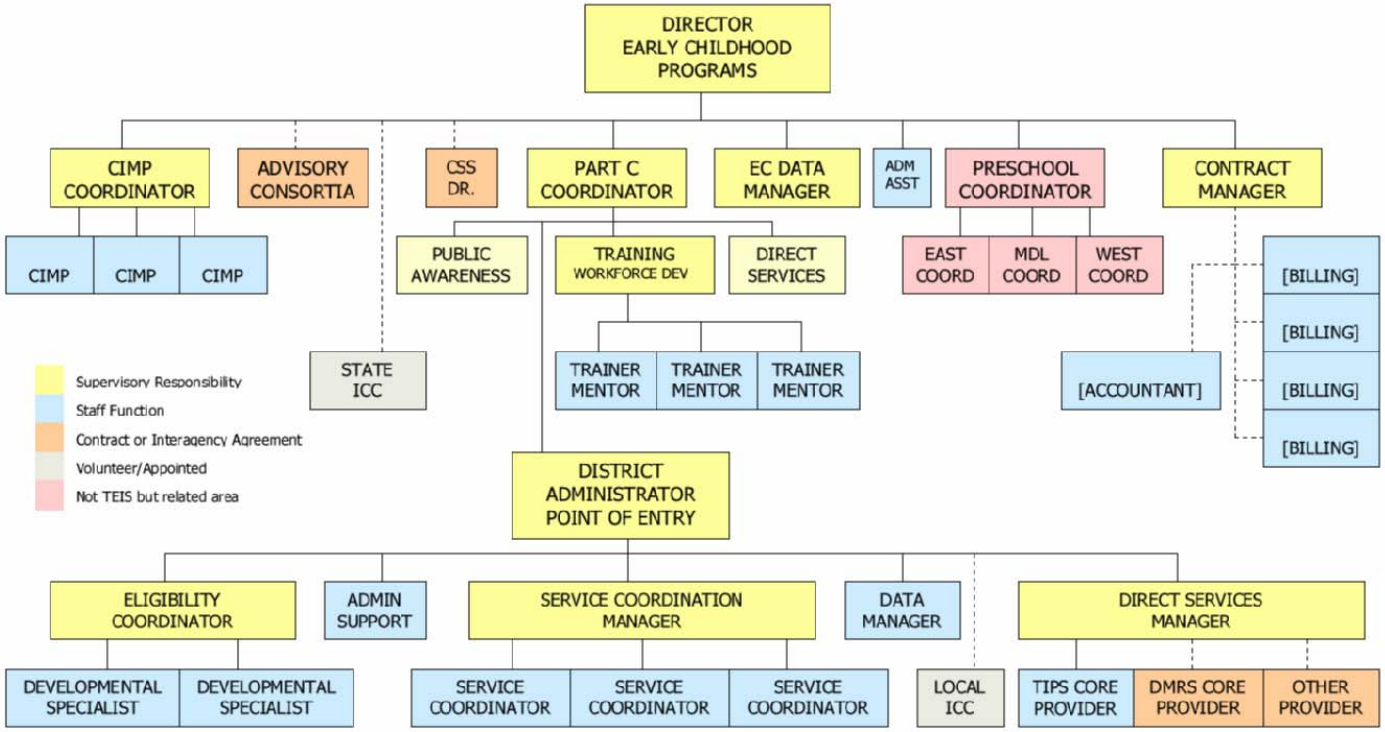
MODEL

TEIS ELIGIBILITY DETERMINATION & IFSP DEVELOPMENT

REFORM DOCUMENT 1



MODEL
STATE & DISTRICT TEIS ORGANIZATIONAL STRUCTURE



1. Chromosomal/Genetic
   - Trisomies, Translocation, Deletions
     - Down Syndrome
     - Williams Syndrome
     - Cri-du-chat
   - All unbalanced structural chromosome Syndromes
   - Prader-Willi Syndrome
   - Klinefelter Syndrome
   - Angelman Syndrome
   - Velo-cardio-facial or DiGeorge Syndrome
   - Sex-linked
     - Fragile X Syndrome
     - Lowe Syndrome
     - FG Syndrome

2. Syndromal
   - Cockayne Syndrome
   - Bardet-Biedl Syndrome
   - Cornelia de Lange Syndrome
   - Rubenstein-Taybi Syndrome

3. Neuromuscular Disorders
   - Cerebral Palsy
   - Muscular Dystrophy
     - Duchenne Type
     - Becker Type
   - Myopathies
   - Anterior Horn Cell Disorders
     - Werdnig-Hoffman Syndrome
     - Kugelberg-Wehlander Syndrome

4. Neurocutaneous Disorders
   - Sturge-Weber
   - Tuberous Sclerosis
   - Neurofibromatosis Type 1

5. Spinal Cord Injury with Cord Involvement

6. Musculoskeletal Diseases
   - Arthrogryposis
   - Reduction Deformity

7. Central Nervous System
   - Congenital Brain Malformation
   - Encephalocele
   - Spina Bifida
   - Hypoxic Ischemic Encephalopathy with Seizures

8. Orofacial Abnormalities
   - Treacher Collins
   - Pierre-Robin Sequence
   - Moebius Sequence
   - Wardenburg Syndrome, Types I and II

9. Autistic Spectrum Disorders including Pervasive Developmental Delay

10. Sensory Loss
    - Vision
      - Albinism
      - Aniridia
      - Anophthalmia
      - Aphakia
      - Cataracts
      - Coloboma
      - Congenital Glaucoma
      - Cone Rod Dystrophy
      - Cortical Visual Impairment
      - Delayed Visual Development/ Maturation/Impairment
      - Familial Exudative Vitreoretinopathy (FEVR
      - Glaucoma
      - Homonymous Hemianopsia
      - Leber's Congenital Amaurosis
      - Microphtthalmia
      - Optic Atrophy
      - Optic Nerve Hypoplasia
      - Peter's Anomaly
      - Persistent Hyperplastic Primary Vitreous(PHPV)
      - Phthisis Bulbi
      - Pigment Retinopathy
      - Retinal Detachment
      - Retinoblastoma
      - Retinopathy of Prematurity (ROP) Stages/Grades 3,4,5

Hearing
- Aided or Unaided Sensorineural Hearing Loss
  - Bilateral mild to profound
  - Unilateral moderate to profound
- Aided or Unaided Conductive Hearing Loss
  - Chronic recurrent middle ear pathology
  - Structural anomalies
- Aided or Unaided Mixed Hearing Loss (Conductive and Sensorineural)
  - Bilateral mild to profound
  - Unilateral moderate to profound
- Cochlear Implant

Deafblind-The term "infants and toddlers with deafblindness" means those under age 3 who are experiencing developmental delays in hearing *and* vision, or have a diagnosed physical or mental condition that has a high probability of resulting in developmental delays in hearing *and* vision.

The following are guidelines, provided through the national deafblind census, for use in determining if any early intervention child is deafblind, e.g. the child has both a vision and hearing impairment.

Visual Impairment
- Low vision (visual acuity of 20/70 to 20/200 in the better eye with correction)
- Legally Blind (visual acuity of 20/200 or less, or field restriction of 20 degrees or in the better eye with correction)
- Light Perception Only
- Totally blind
- Cortical Visual Impairment
- Diagnosed Progressive Loss

Hearing Impairment
- Mild (26-40 dB loss)
- Moderate (41-55dB loss)
- Moderately Severe (56-70 dB loss)
- Severe (71-90 dB loss)
- Profound (91 + dB loss)
- Diagnosed Progressive Loss

11. Abnormalities of Metabolism
- Amino Acid
  - Maple Syrup Urine Disease
  - Untreated PKU
- Fatty acid oxidation
  - MCAD
  - LCHAD
- Galactosemia
- Homocystinuria
- Lipid
  - Infantile Gaucher Disease
  - Niemann-Pick Disease
  - Tay-Sachs Disease
- Purine/Pyrimidine
  - Lesch-Nyhan Syndrome
- Thyroid
  - Untreated Hypothyroidism
- Mucopolysaccharidosis
  - Hunter Syndrome
  - Hurler-Scheie Syndrome
  - Sanfilippo Syndrome
  - Sly Syndrome
- Organic Acid
  - Methylmalonic academia
  - Proprionic acidema
- Urea cycle
  - Ornithine transcarbamylase

12. Ventilator Dependent

13. Congenital Infections
- Cytomegalovirus
- Herpes
- HIV
- Rubella
- Syphillis
- Toxoplasmosis

14.Environmental Agents
- Fetal Alcohol Syndrome
- Fetal Valproate Syndrome
- Fetal Hydantoin Syndrome

15.Prematurity under the following conditions
- Born at a gestational age of less than 30 weeks OR
- Born at a gestational age of 30-36 weeks AND or c the following:
  - Intrauterine growth retardation (IUGR) less than the 10th percentile
  - Hypoxic ischemic encephalopathy

Seizure activity in neonatal period
Intraventricular hemorrhage (IVF) grade lll/IV
Abnormal CT/US findings, including ischemia, thrombosis, significant hydrocephalus, jaor malformations, disorders of myelination
Microcephaly at less than 10th percentile for Gestational age
Metabolic derangement: inborn error of metabolism, prolonged hypoglycemia more than eight hours, bilirubin reaching exchange level OR

Born at a gestational age of 30-36 weeks AND meets at least 2 or more of the following:

Apgar score of less than three at 5 minutes
Prolonged ventilation for apnea or hypoventilation for more than 48 hours
Prolonged hypoxemia greater than 24 hrs
Hypotonia for more than 48 hours
Prolonged hypotension for more than eight Hours

16. Infant Mental Health Disorder
Deprivation/Maltreatment Disorder
Depression of Infancy and Early Childhood
Type I: Major Depression
Type II: Depressive Disorder NOS
Infantile Anorexia

- Identify target audiences, locations and methods to reach them including these possibilities:

Audience	Methods	Locations
General Public	Public Service Announcements Talk Shows Parent Education/Child Development info Print Materials	Radio/TV/Movie Theaters Buses/Benches VCRs, Drs' Waiting Rooms Walmart; Toys R Us Grocery stores
Non-English Speaking Families	Translated materials	Ethnic communities
Professionals o Physicians o Residents in Community Rotation o Public Health Staff o Social Workers, other DHS WIC staff o Program Directors o Hospitals/NICUs	Increase START Training Collaborate w/ Medical Schools Routine collaboration w/ Service Coordination Manager Periodic updates by Service Coordination Manager	Offices, Physician groups Medical Schools Public Health Offices DHS Offices Child Care Programs.
Community Organizations o Advocacy Groups o Urban Child Institute o Catholic Charities o Goodwill o Others		

- Address methods to sustain the momentum of PA approaches such as PSAs when the service is not being actively promoted.
- Identify champions to promote and serve as spokespeople for TEIS.
- Utilize LICCs to tailor Public Awareness at the local level and to evaluate effectiveness PA approaches.
- Focus on digital outreach. Identify and link TEIS information w/ medical community, professional organizations and family sites.

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DIVISION OF SPECIAL EDUCATION
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COMMISSIONER

TEIS Policy Manual Memorandum #06-002 REFORM DOCUMENT 5

DATE: November 27, 2006

TO: TEIS Project Coordinators, TEIS Principal Investigators and TEIS Contract Coordinators

FROM: Jamie Thomas Kilpatrick, Director
Office of Early Childhood Programs, Division of Special Education

RE: **Eligibility Determination**

The Tennessee Division of Special Education's Office of Early Childhood has been reviewing Part C practices, working with the Office of Special Education Program's (OSEP). Division personnel are currently conducting an extensive review of State and Federal IDEA Part C Regulations and eligibility determination procedures. Based on the evaluation of these regulations, practices and written OSEP clarifications, several inconsistencies have been noted. In an attempt to be proactive about these inconsistencies, it is necessary to provide written documentation for policy and procedural clarification related to eligibility determination. The Tennessee Division of Special Education's Office of Early Childhood is committed to full compliance with the Individuals with Disabilities Education Act (IDEA) Regulations as well as implementing timely eligibility determinations. Consultation with OSEP referred Tennessee to the Policy Letter dated October 24, 2003, *Letter to Goodman.*

I. Initial evaluation for eligibility

If the child has been evaluated by a doctor, nurse practitioner, or pediatric nurse*, as evidenced by a review of pertinent records related to the child's current health status and medical history, it is allowable to have one additional evaluator from another discipline assess the child's level of functioning in each of the following developmental areas: (A) cognitive development; (B) physical development, including vision and hearing; (C) communication development; (D) social or emotional development; and (E) adaptive development. This eligibility determination practice meets the definition of multidisciplinary evaluation. Part C does not require that, in conducting a "comprehensive, multidisciplinary evaluation of each child", each child be evaluated by more than one evaluator in any particular development area. Specifically "*multidisciplinary* means the involvement of two or more disciplines or professions in the provision of integrated and coordinated services, including evaluation and assessment activities in §303.322…." 34 CFR §303.17.

*Reference State of Tennessee Rules of State Board of Education Rule 0520-1-10-.02(9) (b) 2. (vi) for IDEA defined disciplines.

Under Part C regulations at 34 CFR §303.322(a)(1), the State "system must include the performance of a timely, comprehensive, multidisciplinary evaluation of each child, birth through age two, referred for evaluation…." The Part C regulations require that the evaluation and assessment be conducted by personnel trained to utilize appropriate methods and procedures. 34 CFR §§303.323(c) and 303.323(d). The regulations also specify that no single procedure is used as the sole criterion for determining eligibility. 34 CFR §303.322. The evaluation and assessment of each infant or toddler must be based on informed clinical opinion, and include the following:

(i) a review of pertinent records related to the child's current health status and medical history;
(ii) an evaluation of the child's level of functioning in each of the following developmental areas: (A) cognitive development; (B) physical development, including vision and hearing; (C) communication development; (D) social or emotional development; and (E) adaptive development;
(iii) an assessment of the unique needs of the child in terms of each of the developmental areas in paragraph (c) (3) (ii) of this section, including the identification of services appropriate to meet those needs for determining a child's eligibility.

34 CFR §303.322(c)

Therefore, **effective immediately upon receipt of this memorandum**, Point of Entry eligibility determination practices should adhere to the following procedures:
The multidisciplinary team for every child will include:

- A developmental evaluator, which:
  i. Meets the Tennessee Professional Standards for Early Childhood Education and/or Early Childhood Special Education; or
  ii. Have verification of formal training and experience in the field of early childhood development and/or early intervention; and
  iii. Have experience in conducting developmental evaluations of young children.
- A medical professional, which must include one of the following:
  i. Physician;
  ii. Nurse practitioner; or
  iii. Pediatric nurse.

It is not consistent with IDEA to require additional evaluative measures for an individual child in order to determine eligibility for Part C. Any additional concerns in a specialty area (i.e. speech, hearing, physical therapy, occupational therapy) would only be addressed at the initial IFSP meeting or subsequent IFSP meetings. Requiring additional evaluative measures to determine eligibility places an undue burden on families and is a barrier to the implementation of the initial IFSP. (Part C funds may not be utilized to pay for these specialties evaluative measures prior to the initial IFSP).

The Office of Early Childhood is committed to working with all parties involved with the implementation of these procedures. Non compliance with this policy and practice clarification will result in potential termination of contract for cause. Department of Education procedures will be immediately be put in to place to ensure compliance with this policy and practice clarification.

UNIFORM SERVICE DEFINITIONS
TENNESSEE'S EARLY INTERVENTION SYSTEM

Early Intervention Services.
Derived from TEIS Rules, Chapter 0520-1-10
These definitions are not substituted for those in Rule.

General.

Quality early intervention service provision is the result of a process that is based in the routines that are natural to the lifestyle of the individual family and child. This process results in the development of strategies to enhance learning environments. Therefore, the discussion of natural environments is not only about locations where services are provided, but also about a process, which identifies when and where in a family's normal routines interventions will be most effective.

Early intervention services are selected in collaboration with parents, provided under public supervision by qualified personnel in conformity with an IFSP that meets the State standards established under this rule. They are provided at no cost to parents unless the State has an established schedule of sliding fees including policies which specify what services will be provided at no cost and what services are subject to a system of payments. Fees will not be charged for the services that a child is otherwise entitled to receive at no cost to parents under IDEA Part C. To the maximum extent appropriate to the needs of the child, early intervention services must be provided in natural environments including home and community settings in which children without disabilities participate and in environments which are considered natural or normal for the child's age peers who have no disability.

Individuals or agencies designated as responsible parties for implementing the action steps documented in the IFSP shall maintain a system that describes the method(s) utilized to show how progress toward achieving the IFSP outcomes will be determined including:

(i) The methods and/or procedures utilized in monitoring the implementation of the action and its impact on the child's or family's progress toward achieving the outcomes;

(ii) The frequency with which progress is monitored; and

(iii) The person(s) responsible for documenting the child's or family's progress and reporting on that progress to the IFSP team for periodic reviews (at a minimum, the six (6) month review, and the annual IFSP).

Early intervention services necessary to meet the unique needs of the child and the child's family shall be determined by the IFSP team and documented on the IFSP and may include, but not be limited to:

1. Assistive technology devices and services.

Assistive technology means any item, piece of equipment or product system, whether acquired commercially off the shelf or modified or customized, that is used to increase, maintain or improve the developmental capabilities of children with disabilities.

(i) Part C of IDEA deals only with assistive technology that is directly relevant to the developmental needs of the child. Assistive technology devices must be necessary for the child to accomplish IFSP goals/objectives within their everyday activities and routines.
(ii) IDEA specifically excludes services that are surgical in nature and devices necessary to control or treat a medical condition.
(iii) Equipment/devices must be developmentally appropriate to be considered eligible for funding.
(iv) AND it means a service that directly assists a child with a disability in the selection, acquisition, or use of an assistive technology device.

Assistive technology services include:

(i) The evaluation of the needs of a child with a developmental delay, including a functional evaluation of the child in the child's natural environment;
(ii) Purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for children with developmental delays;
(iii) Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing assistive technology devices;
(iv) Coordinating and using other therapies, interventions, or services with assistive technology devices such as those associated with existing education and rehabilitation plans and programs;
(v) Training or technical assistance for a child with developmental delays and that child's family or caregiver;
(vi) Training or technical assistance for professionals (including individuals providing Early Intervention Services) or other individuals who provide services to or are otherwise substantially involved in the major life functions of children with disabilities.

2. Audiology which includes:

(i) Identification of children with auditory impairments, using at risk criteria and appropriate audiologic screening techniques;

(ii) Determination of the range, nature, and degree of hearing loss and communication functions, by use of audiological evaluation procedures;

(iii) Referral for medical and other services necessary for the habitation or rehabilitation of children with auditory impairments;

(iv) Provision of auditory training, aural rehabilitation, speech reading and listening device orientation and training, and other services;

(v) Provision of services for prevention of hearing loss; and

(vi) Determination of the child's need for individual amplification, including selecting, fitting and dispensing appropriate listening and vibrotactile devices, and evaluating the effectiveness of those devices.

3. Developmental Therapy: Developmental Therapy Services are early intervention services for children under three years of age that have been identified as necessary in the IFSP and recommended by a Developmental Specialist and/or credentialed/licensed practitioner or physician or other licensed practitioner of the healing arts within the scope o his/her practice under state law. Developmental Therapy covers two basic services:

A. Developmental Testing: Assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments.

This service is a diagnostic process necessary for determining a child's initial and continuing eligibility, developmental status and need for medically necessary developmental services. This includes assessment of motor, language, adaptive and/or cognitive functioning by standardized developmental instruments authorized by the State such as BDI-2, Early Learning Accomplishment Profile (E-LAP), HELP, AEPS, Carolina, INSITE, Callier-Azusa. This service is limited to four one hour units per calendar year.

Specific activities include administration of the instrument, interpretation of test scores with informed clinical opinion and provision of [written] narrative report. The report(s) describe(s) a child's developmental functioning in each of the areas compared with other children of the same chronological age, and the skills to be remediated. Results of Developmental Testing are included in development of the IFSP. Developmental Testing does not include medical, speech therapy, occupational therapy, physical therapy, audiological or vision

evaluations.

B. Developmental Intervention

Part 1: Developmental Intervention is defined as direct one with one/therapist with child or caregiver contact by a provider, using dynamic activities to improve child's functional skills, for up to four sessions per week, 15 minutes each, or a 1 hour equivalent per eligible child. The service is provided with the child and child's care giver to promote cognitive, motor, adaptive and communication skills and social/emotional development.

Developmental services include:

(i) Planned interaction of personnel, materials, time and space to provide developmental intervention;
(ii) Provision of information to the family about therapeutic curriculum planning; Information to families about the child's skill levels and how to enhance the child's development.
(iii) Skills training and support to the care givers to foster, promote and enhance child engagement in daily activities, functional independence and social interaction.
(iv) Assistance to care givers in identification and use of opportunities to incorporate developmental strategies in normal daily routines of the child and family.
(v) Monitoring of child progress and mastery of functional skills to overcome developmental limitations.
(vi) Provision of emotional support for families.

Developmental therapy services

Part 2: Services which may be provided in the child/family's home or community setting which conforms to the State's criteria for Natural Environments. Part C of IDEA's Lead Agency requires the following for developmental therapy services:

(i) The TEIS POE will implement the concept of a "core provider" (developmental therapist) who shall be identified as a potential service provider prior to the initial IFSP meeting based upon areas of expertise that best meet the needs identified by the family and shall be provided at a maximum of 1 hour/week.
(ii) The combined total of all other required services listed on an IFSP shall have a **maximum** of 48 service hours over 6 months. This would include a combined total of no more than 2 service hours per week.
(iii) Group services for developmental therapy may be provided in addition to all other required service hours for a **maximum** of 10 hours per week per child (limited to 4 days @ 2.5 hours/day). Regardless of the intensity of hours, this requirement would include a minimum of one 15 minute individual parent consult session per week.

Part 3: A required procedure would be to conduct an IFSP meeting that included the Direct Services Manager/Service Coordination Manager. The IFSP team would then have to agree that the child and family goals could not be satisfactorily met without this intensive service provision.

The group service cannot supplant an existing, or potentially arranged, child care, regardless of the payor source. The focus of the developmental therapist will be to partner with the Child Care Resource and Referral Center inclusion specialist and the childcare provider to insure appropriate methodologies within the daily routine of the childcare placement. Documentation requirements to be included in the discussion include the following:

(i) Routines based interview
(ii) Age of the child
(iii) Documentation of how the group intervention methodologies will be integrated in the home via developmental therapist/core provider
(iv) The family's proximity to the placement being considered
(v) Documentation noting the exhausted efforts to utilize all other payor sources and placement options
(vi) Transportation Agreement signed by the parent, documenting the understanding that any transportation to and from the service is the responsibility of parent
(vii) Service coordination which includes assistance and services provided by a service coordinator to an eligible child and the child's family that are in addition to the functions and activities included under 0520-1-10-.02(6).

4. Family training, counseling, home visits, parent-to-parent interaction, and support groups which include services provided, as appropriate, by social workers, psychologists, and other qualified personnel to assist the family of an eligible child in understanding the special needs of their child and enhancing the child's development. [Included within Developmental Therapy].

5. Health services which include services necessary to enable a child to benefit from other early intervention services during the time that the child is receiving other early intervention services

Health services do not include services that are:

I. Surgical in nature such as cleft palate surgery, surgery for clubfoot, or the shunting of hydrocephalus;

II. Purely medical in nature such as hospitalization for management of congenital heart ailments, or the prescribing of medicine or drugs for any purpose, or devices necessary to control or treat a medical condition; or

III. Medical-health services such as immunizations and regular "well-baby" care that are routinely recommended for all children.

6. Medical services only for diagnostic or evaluation purposes which include services provided by a licensed physician to determine a child's developmental status and/or diagnosis indicating the need for early intervention services.

7. Nursing services which include:

(i) The assessment of health status for the purpose of providing nursing care including the identification of patterns of human response to actual or potential health problems;

(ii) Provision of nursing care to prevent health problems, restore or improve functioning,

(iii) Promotion of optimal health and development; and

(iv) Administration of medications, treatments, and regimens prescribed by a licensed physician.

8. Nutrition services which include:

(i) Conducting individual assessments in:

(I) Nutritional history and dietary intake;

(II) Anthropometric, biochemical, and clinical variables;

(III) Feeding skills and feeding problems; and

(IV) Food habits and food preferences;

(ii) Developing and monitoring appropriate plans to address the nutritional needs of eligible children based on assessments/evaluations; and

(iii) Making referrals to appropriate community resources to carry out nutrition goals.

9. Occupational therapy which includes services to address the functional needs of a child related to the performance of adaptive skills, adaptive behavior and play, and sensory, motor, and postural development. These services are designed to improve the child's functional ability to perform tasks in home, school, and community settings, and include:

(i) Identification, assessment, and intervention;

(ii) Adaptations of the environment and selection, design, and fabrication of assistive and orthotic devices to facilitate development and promote the acquisition of functional skills; and

(iii) Prevention or minimization of the impact of initial or future impairment, delay in development, or loss of functional ability.

10. Physical therapy which includes services to address the promotion of sensorimotor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation. These services include:

(i) Screening, evaluation, and assessment of infants and toddlers to identify movement dysfunction;

(ii) Obtaining, interpreting, and integrating information appropriate to program planning to prevent or alleviate movement dysfunction and related functional problems; and

(iii) Providing services to prevent or alleviate movement dysfunction and related functional problems.

11. Psychological services which include:

(i) Administering psychological and developmental tests, and other assessment procedures;

(ii) Interpreting assessment results;

(iii) Obtaining, integrating, and interpreting information about child behavior, and child and family conditions related to learning, mental health, and development; and

(iv) Planning and managing a program of psychological services, including psychological counseling for children and parents, family counseling, consultation on child development, parent training, and education programs.

12. Social work services which include:

(i) Making home visits to evaluate a child's living conditions and patterns of parent-child interaction;

(ii) Preparing an assessment of the child within the family context;

(iii) Providing individual and family-group counseling with parents and other family members, and appropriate social skill-building activities with the child and parents;

(iv) Working with those problems in a child's and family's living situation (home, community, and any center where early intervention services are provided) that affect the child's maximum utilization of early intervention services; and

(v) Identifying, mobilizing, and coordinating community resources and services to enable the child and family to receive maximum benefit from early intervention services.

13. Special instruction which includes [Services included within Developmental Therapy and no longer a single service]:

(i) The design of learning environments and activities that promote the child's acquisition of skills in a variety of developmental areas; including cognitive processes and social interaction;

(ii) Curriculum planning, including the planned interaction of personnel, materials, and time and space, that leads to achieving the outcomes in the child's IFSP;

(iii) Providing families with information, skills, and support related to enhancing the skill development of the child; and

(iv) Working with the child to enhance the child's development.

14. Speech-language pathology which includes:

(i) Identification of children with communicative or oral pharyngeal disorders and delays in development of communication skills, including the diagnosis and appraisal of specific disorders and delays in those skills;

(ii) Referral for medical or other professional services necessary for the habilitation or rehabilitation of children with communicative or oral pharyngeal disorders and delays in development of communication skills; and

(iii) Provision of services for habilitation, rehabilitation, or prevention of communicative or oral pharyngeal disorders and delays in development of communication skills.

15. Transportation which includes the cost of travel such as mileage, or travel by taxi, common carrier, or other means and related costs (e.g., parking expenses) that are necessary to enable an eligible child and the child's family to receive early intervention services.

16. Vision services which include:

(i) Evaluation and assessment of visual functioning, including the diagnosis and appraisal of specific visual disorders, delays, and abilities;

(ii) Referral for medical or other professional services necessary for the habilitation or rehabilitation of visual functioning disorders, or both; and

(iii) Communication skills training, orientation and mobility training for all environments, visual training, independent living skills training, and additional training necessary to activate visual motor abilities.

Assistive Technology Equipment 2/1/2001

Black- both states agree; Orange- Illinois, Blue- South Carolina

2/1/01 list **8/22/05 list**

REFORM DOCUMENT 7

HCPCS	Description	Prior Approval	Order Needed	Maximum Allowable Price	Maximum Quan/Days	Examples
C1500	Adaptive, utensil, feeding	Y	N	N/A	2/1095	Weighted or built-up fork or spoon
C1510	Adaptive, cup, nosey	Y	N	N/A	2/365	
C1599	ADL/adaptive, miscellaneous	Y	Y	N/A	N/A	
					calculated manually	
W7265	AFO, addition, foot/calf strap, each	Y	Y	14.25	N/A	
L1902	AFO, ankle gauntlet	Y	Y	56.75	N/A	
	" " , prefabricated, includes fitting and adjustment, each			55.65	2/365	
L1904	AFO, ankle gauntlet, molded	Y	Y	343.18	N/A	
	" " " custom fabricated, each			318.58	2/365	
L1990	AFO, double upright, plantar dorsiflex, solid stirrup, calf cuff	Y	Y	355.29	N/A	
	"" "" (double bar "BK" orthosis) custom fabricated, each			319.46	2/365	
L1930	AFO, plastic	Y	Y	191.54	N/A	
	" " or other material, prefabricated, includes fitting and adjustments,each			160.27	2/365	
L1940	AFO, plastic, molded to patient	Y	Y	370.22	N/A	
	" " or other material, custom fabricated, each				362.19 2/365	
L1960	AFO, plastic, molded to patient, posterior solid ankle	Y	Y	471.26	N/A	
	" " " " custom fabricated, each			375.52	2/365	
L1950	AFO, plastic, molded to patient, spiral	Y	Y	584.70	N/A	
L1970	AFO, plastic, molded to patient, with ankle joint	Y	Y	526.22	N/A	
	" " " " each			555.41	4/365	
W7133	AFO, prefabricated	Y	Y	47.41	N/A	
L1920	AFO, single upright with static or adjustable stop	Y	Y	312.32	N/A	
	" " custom fabricated, each (Phelps or Peristein type)			236.84	2/365	
L1980	AFO, single upright, plantar dorsiflex, solid stirrup, calf cuff	Y	Y	306.99	N/A	
	" " "" calf band/cuff (single bar "BK" orthosis), custom fab, each			248.64	2/365	
L3999	Upper limb orthosis, NOS	Y	Y	55.00	4/365	
W8665	Bath chair	Y	Y	N/A	1/1095	Chair, bath support
X1942	Bath chair	Y	Y	354.00	1/1095	Chair, bath support
W7952	Bench, transfer, unpadded	Y	N	115.41	N/A	Positioning bench
W7171	Benik hand splint	Y	Y	32.57	N/A	
W7170	Benik knee support	Y	Y	40.00	N/A	
W7173	Benik vest	Y	Y	104.00	N/A	

Orange- Illinois, Blue- South Carolina
2/1/01 list 8/22/05 list

HCPCS	Description	Prior Approval	Order Needed	Maximum Allowable Price	Maximum Quan/Days	Examples
W8863	Communication system, non- or low-technical, $499 or less	Y	Y	N/A	N/A	Symbol systems, communication boards
L3140	Foot, abduction rotation bar, including shoes	Y	Y	66.73	N/A	
L3150	Foot, abduction rotation bar, without shoes	Y	Y	61.01	N/A	
L3000	Foot, insert, removable UCB type, berkely shell, molded, each	Y	Y	235.47	N/A	
L3030	Foot, insert, removable, formed to patient foot, each	Y	Y	57.20	N/A	
L3010	Foot, insert, removable, longitudinal arch support, molded, each	Y	Y	130.59	N/A	
L3020	Foot, insert, removable, longitudinal/metatarsal support, molded	Y	Y	131.50	N/A	
L3001	Foot, insert, removable, spenco, molded to patient, each	Y	Y	63.50	N/A	
L3170	Foot, plastic heel stabilizer	Y	Y	37.50	N/A	
W8964	Gait trainer, any type	Y	Y	N/A	1/1095	
C2010	Hearing aid, alligator clip	N	N	8.00	N/A	
W8178	Hearing aid, battery, silver, any size, each	N	N	3.37	24/365	
W8158	Hearing aid, battery, zinc air, any size, each	N	N	1.66	24/365	
V5266	Hearing aid, battery, any size, each	N	N	3.37	N/A	
W8187	Hearing aid, binaural	Y	Y	N/A	N/A	
W7121	Hearing aid, dispensing fee, binaural	N	N	372.00	N/A	
W7130	Hearing aid, dispensing fee, monaural	N	N	231.00	N/A	
W8183	Hearing aid, ear mold, each	N	N	39.64	N/A	
V5264 RT	Ear molds (not disposable) RT= Right	N	N	9.50	5/365	(+ actual cost, total not to exceed $54.00)
V5264 LT	" LT= Left					
V5265	RT & LT Ear mold insert, disposable any type	N	N	not listed		
W8188	Hearing aid, monaural	Y	Y	N/A	N/A	
W8192	Hearing aid, monaural creating binaural set	Y	Y	N/A	N/A	
C2000	Hearing aid, pediatric care kit	N	N	50.00	1/1095	All accessory items for hearing aid
W8184	Hearing aid, repairs, less that $100	N	N	100.00	N/A	
W8185	Hearing aid, repairs, over $100	Y	N	N/A	N/A	
V5014 RT	Hearing aid, repairs RT=right	N	N	Actual cost total not to exceed 135.00(plus S&H V5267)		
V5014 LT	" repairs LT=Left	"	"	2/365 per ear manufacturer invoice required)		
W8186	Hearing aid, Replacement cord	N	N	22.80	2/365	
W7318	Hearing aid, stethoscope	N	N	10.88	1/1095	
V5090	Handling/Dispensing Fee, Unspecified hearing aid	N	N	8.00	5/365	
V5267	Hearing Aid Supplies	Y	N	cost	1/1095	

Orange- Illinois, Blue- South Carolina
2/1/01 list 8/22/05 list

HCPCS	Description	Prior Approval	Order Needed	Maximum Allowable Price	Maximum Quan/Days	Examples
(A child may only receive one of the following four items V5030-V5060, per ear, during the 1095 days)						
V5030	Hearing Aid, Monaural, Body worn, air conduction	Y	Y	up to	1/ear 1095	Manufacturer list price plus S&H-V5267
V5040	Hearing Aid, Monaural, Body worn, bone conduction			900.00		manufacturer invoice required
V5050	Hearing Aid, Monaural, in the ear					
V5060	Hearing Aid, Monaural, behind the Ear (CIC and ITC)					
V5011	Hearing Aid orientation	N	N	35.00/hr	5/365	
V5014-000	Replace tubing or ear hook	N	N	5.00	N/A	
L3350	Heel wedge	Y	Y	17.16	N/A	
L2040	HKAFO, torsion control, bilateral rotation straps	Y	Y	153.80	N/A	
	“”””” pelvic band/belt, custom fabricated, each			123.72	2/365	
L2050	HKAFO, torsion control, bilateral torsion cables, hip joint straps	Y	Y	370.49	N/A	
	“”””” pelvic band/belt, custom fabricated, each			329.50	2/365	
L2070	HKAFO, torsion control, unilateral rotation straps	Y	Y	117.99	N/A	
	“”””” pelvic band/belt, custom fabricated, each			121.48	2/365	
L2080	HKAFO, torsion control, unilateral, cable hip joint	Y	Y	283.73	N/A	
	“”””” pelvic band/belt, custom fabricated, each			287.84	2/365	
L2270	LE addition, varus/valgus correction “T” strap, malleolus pad	Y	Y	46.86	N/A	
	“”””””” each			36.39	4/365	
L2210	LE, addition, dorsiflexion, plantar flexion assist, each joint	Y	Y	47.78	N/A	
				52.27	8/365	
L2220	LE, addition, dorsiflexion, plantar flexion assist/resist, each	Y	Y	61.51	N/A	
	“”””” each joint			60.01	8/365	
L2250	LE, addition, foot plate, molded to patient, stirrup attachment	Y	Y	253.95	N/A	
	“”””” each			240.73	4/365	
L2200	LE, addition, limited ankle motion, each, joint	Y	Y	38.20	N/A	
	“ “ dorsiflexion and pantar flexion assist/resist, each joint			31.21	8/365	
L2240	LE, addition, round caliper/plate attachment	Y	Y	72.73	N/A	
	“ “ “ each			56.66	4/365	

L2820	LE, addition, soft interface for molded plastic	Y	Y	61.73	N/A
	" " " below knee section			58.83	2/365
L2230	LE, addition, split flat caliper stirrups, plate attachment	Y	Y	72.73	N/A
	" " " " each			51.98	2/365
L2275	LE, addition, varus/valgus correction, plastic modification	Y	Y	99.10	N/A
	" " ' " padded/lined each			88.52	3/365
L2999	Lower extremity orthosis, not otherwise classified	Y	Y	N/A	N/A
				55.00	4/365

Orange- Illinois, Blue- South Carolina
2/1/01 list 8/22/05 list

HCPCS	Description	Prior Approval	Order Needed	Maximum Allowable Price	Maximum Quan/Days	Examples
L3206	Orthopedic shoe, hightop with supinator or pronator, child	Y	Y	85.00	N/A	
L3204	Orthopedic shoe, hightop with supinator or pronator, infant	Y	Y	83.20	N/A	
L3202	Orthopedic shoe, oxford with supinator or pronator, child	Y	Y	81.50	N/A	
L3201	Orthopedic shoe, oxford with supinator or pronator, infant	Y	Y	80.50	N/A	
E0189	Pad, Sheepskin, Lambs wool, any size	Y	Y	66.09	1/60	
E0188	Pad, Sheepskin, synthetic, any size	N	Y	19.05	1/60	
W8666	Pediatric floor sitter, feeder seat	Y	Y	N/A	N/A	Feeder seat
W7184	Pediatric/youth, positioning, activity, floor chair	Y	Y	N/A	N/A	Corner chair
C3010	Roll, bolster, any size	Y	Y	89.00	N/A	Raised, half
W7355	SMO	Y	Y	277.88	N/A	
W8667	Stander, any type, with or without wheels	Y	Y	N/A	N/A	Prone, supine, tri standers
C1000	Switch activated device	Y	N	N/A	2/1095	
C1010	Switch, battery adapter	N	N	N/A	2/1095	
C3000	Therapy ball, any size	N	N	35.00	1/1095	Gymnic, peanut
L1500	THKAO, mobility frame	Y	Y	1467.97	N/A	
L1510	THKAO, standing frame	Y	Y	904.30	N/A	
E0135	Walker, folding, pickup	Y	Y	79.97	1/365	
				61.13		
E0143	Walker, folding, wheeled	Y	Y	87.28	1/365	
				85.63		
W8965	Walker, forearm support, attachment	Y	Y	66.33	N/A	
E0158	Walker, leg extensions, per set of four	Y	Y	30.69	1/1095	
W8962	Walker, pelvic stabilizer attachment	Y	Y	71.74	N/A	
E0130	Walker, rigid, pickup	Y	Y	40.26	1/365	
E0141	Walker, rigid, wheeled	Y	Y	101.66	1/365	
E0155	Walker, wheel attachment for pick-up walker, pair	Y	Y	25.19	1/1095	
W7186	Wedge, floor therapy	Y	N	165.46	N/A	
C3030	Weighted blanket, any size	Y	N	N/A	N/A	

C3020	Weighted vest, any type	Y	N	N/A	N/A
C3050	Weights, miscellaneous	Y	N	N/A	N/A
L3805	WHFO, long opponens, no attachment	Y	Y	232.38	N/A
				212.10	4/365
L3800	WHFO, short opponens, no attachment	Y	Y	150.38	N/A
				132.56	4/365
X1934	Feeder Seat, any size	Y	Y	280.42	1/1095
E-1399-HA	Floor Sitter, any size	Y	Y	321.66	1/1095
X1955	Corner Chair	Y	Y	281.00	1/1095
A thought for TN is:	Wheelchair	Y	Y	within $500.00-1000.00 range	

REFERENCE:
South Carolina
Illinois

Key:

HCPCS – Procedure code for Item/Service

Prior Approval Indicator - N= No prior approval is required by _____
Y= Prior approval required by _____

Order Needed Indicator - N= No physician's order needed
Y= Physician's order needed

Maximum Allowable Price – State maximum allowable purchase price. If N/A indicated, item is priced individually based on request submitted.

Maximum Quantity/Days Indicator – If applicable, indicates the maximum quantity that may be dispensed within the number of days shown.

Quantities that exceed maximum allowable quantity shown require prior approval by _____

Examples – Example of items that might be described by specific HCPCS code.

Note: for items not included on list the TN Medicaid Maximum Price and Maximum Quantity/Days will be used when applicable.

Position Title	Skill Area	Topical Training Areas
District Administrator	Leadership	• Federal, State, and district functions • Personnel recruitment and retention
	Personnel	• Professional development
	Community Leader	• Orientation to community resources • Networking
	Accountability	• Financial management • Laws, regulations, and procedural safeguards • Tennessee Early Intervention Data System (TEIDS) • Overview of the Part C early intervention system
District Data Manager	General	• Overview of the Part C early intervention system • Professional development • Financial management • Tennessee Early Intervention Data System (TEIDS) • Laws, regulations, and procedural safeguards
Eligibility Coordinator	Leadership	• Federal, State, and district functions • Personnel recruitment and retention
	Personnel	• Professional development
	Community	• Orientation to community resources • Networking
	Accountability	• Overview of the Part C early intervention system • Tennessee Early Intervention Data System (TEIDS) • Early Intervention home visits • Family systems • Early childhood development • Laws, regulations, and procedural safeguards • Evaluations and assessments • IFSP
Developmental Specialist	General	• Overview of the Part C early intervention system • Tennessee Early Intervention Data System (TEIDS) • Professional development • Early Intervention home visits • Family systems

Developmental Specialist	General	• Overview of the Part C early intervention system • Tennessee Early Intervention Data System (TEIDS) • Professional development • Early Intervention home visits • Family systems • Early childhood development • Laws, regulations, and procedural safeguards • Evaluations and assessments • IFSP
Service Coordination Manager	Leadership	• Federal, State, and district functions • Personnel recruitment and retention
	Personnel	• Professional development
	Community	• Orientation to community resources • Networking
	Accountability	• Overview of the Part C early intervention system • Tennessee Early Intervention Data System (TEIDS) • Early Intervention home visits • Family systems • Early childhood development • Supports and services in the natural environment • Laws, regulations, and procedural safeguards • Referral and intake • Evaluations and assessments • IFSP • Early intervention transitions
Service Coordinator	General	• Overview of the Part C early intervention system • Tennessee Early Intervention Data System (TEIDS) • Early Intervention home visits • Family systems • Early childhood development • Supports and services in the natural environment • Laws, regulations, and procedural safeguards • Referral and intake • Evaluations and assessments • IFSP

	Community	• Orientation to community resources • Networking
	Accountability	• Overview of the Part C early intervention system • Tennessee Early Intervention Data System (TEIDS) • Early Intervention home visits • Family systems • Early childhood development • Supports and services in the natural environment • Laws, regulations, and procedural safeguards • Evaluations and assessments • IFSP • Early intervention transitions
District Service Provider	General	• Overview of the Part C early intervention system • Tennessee Early Intervention Data System (TEIDS) • Professional development • Early Intervention home visits • Family systems • Early childhood development • Supports and services in the natural environment • Laws, regulations, and procedural safeguards • Evaluations and assessments • IFSP • Early intervention transitions

Potential components for topical training areas:

- ❑ Federal, State, and District functions
  - ➢ Policies
  - ➢ Procedures
  - ➢ Vision
  - ➢ Strategic planning
  - ➢ District supervision and management

- ❑ Personnel recruitment and retention
  - ➢ Interviewing
  - ➢ Hiring
  - ➢ Personnel evaluations
  - ➢ Retention of personnel
  - ➢ Supervision and management

- ❑ Financial management
  - ➢ Budget administration and management
  - ➢ Tracking and reporting

- ❑ Orientation to community resources
  - ➢ Identifying resources
  - ➢ Building district resources
- ❑ Networking
  - ➢ Communication, consensus, and negotiation

- ❑ Overview of the Part C early intervention system

- ❑ Tennessee Early Intervention Data System (TEIDS)
  - ➢ Data entry, accuracy, utilization
  - ➢ Qualitative assurance
  - ➢ Reports

- ❑ Professional development
  - ➢ Position specific orientation
  - ➢ Effective communication – written and oral
  - ➢ Effective time management
  - ➢ Work organization
  - ➢ Conflict resolution
  - ➢ Harmonious and professional work environment
  - ➢ Annual performance evaluation and goal setting

- ❑ Early Intervention home visits
  - ➢ Safety issues
  - ➢ Components of a home visit
  - ➢ Partnering with families
  - ➢ Designing and implementing intervention strategies within family identified routines

- ❑ Family systems
  - ➢ Cultural diversity and values
  - ➢ Components of reciprocal parent and caregiver relationships
  - ➢ Listening skills

- ❑ Early childhood development
  - ➢ Developmental domains
  - ➢ Developmentally appropriate practices
  - ➢ Developmental 'red flags'
  - ➢ Teaching and learning strategies

- ❑ Supports and services in the natural environment
  - ➢ Defining and implementing practices related to natural environments
  - ➢ Services outside the natural environment
  - ➢ Core provider model

- ❑ Laws, regulations, and procedural safeguards
  - ➢ Child abuse and neglect reporting
  - ➢ Child Abuse Prevention and Treatment Act (CAPTA)
  - ➢ Family Educational Rights and Privacy Act (FERPA)
  - ➢ Heath Insurance and Accountability Act (HIPAA)
  - ➢ Individuals with Disabilities Education Act (IDEA), Part C
  - ➢ Tennessee Part C Rules and Regulations
  - ➢ Systems of Payments Policies

- Referral and intake
  - Processes, procedures, and timelines

- Evaluations and assessments
  - Processes, procedures, and timelines
  - Eligibility
  - Family assessments
  - Evaluations
  - Ongoing assessments
  - Office of Special Education Programs (OSEP) Child outcome measures

- IFSP
  - Processes, procedures, and timelines
  - IFSP meeting facilitation
  - Development and implementation
  - Tennessee's IDEA defined early intervention services definitions

- Early intervention transitions
  - Processes, procedures, and timelines

References used to further detail training content:

Tennessee Service Coordination Modules
Tennessee Early Childhood Training Alliance TECTA) - Administrator Orientation Content
Tennessee Early Childhood Training Alliance TECTA) – infant-Toddler Orientation
Developmental Specialist Individualized Professional Development Plan (IPDP) – Self-Assessment Tool, New Mexico
Infant Toddler Family Specialist (ITFS) Manual - Connecticut

Tennessee Department of Education
Division of Special Education
TEIS Vendor Agreement

A. This Agreement, made and entered into on **July 1, 2007**, documents the business rules between The Department of Education (hereinafter DOE), acting on behalf of Tennessee's Early Intervention System (TEIS), and ***_____vendor name_____*** (hereinafter "Vendor"). This Agreement consists of this cover page, the DOE's Standard Terms and Conditions, and the attached Special Terms and Conditions. Terms contained on this cover page, DOE's Standard Terms and Conditions, and Special Terms and Conditions shall prevail over those of any attachment unless otherwise stated under "Other terms" below.

B. Vendor may provide the following services (not to exceed the rates shown) as stated in each eligible child's Individualized Family Service Plan:
See Attachment A

C. The period of performance under this agreement is from **July 1, 2007**, through **June 30, 2008**. However, DOE may terminate this agreement for convenience by giving the other party at least sixty (60) days written notice before the effective termination date, in which event the Contractor shall be entitled to receive from DOE equitable compensation for satisfactory authorized work completed as of the termination date.

D. Any associated charges for these services will be paid by the child's insurance, if any, or TennCare, if applicable. If the child has no insurance, the services are not covered by the insurance, or access to insurance has been denied and TennCare is not applicable, the charges will be paid by the DOE. The primary payor is the entity that is primarily responsible for the payment. The cost of services purchased shall be based on the primary payor's usual and customary fees or negotiated charges as outlined below:

1. If the payment by the primary payor is based on a negotiated charge, then the portion payable by DOE shall be based upon the same negotiated charge. Consequently, DOE shall benefit to the same extent and in the same manner as the primary payor. If payments from other sources equal or exceed the amount of the State's maximum liability as a sole payor, the State will not pay additional fees on any charge.

2. In the event that DOE is the primary payor, as payor of last resort, the payment shall be based on the rates identified above, but not to exceed, the maximum allowable cost for that service as established by this agreement.

3. In no case shall the parent of an eligible child be held responsible for payment of a charge for a required service in accordance with an Individualized Family Service Plan (IFSP) as defined in Part C of IDEA.

E. Other payment terms: When a therapy service is conducted in a natural environment such as the home or community setting, DOE may provide an additional incentive of 25% of the hourly rate listed above in the section B of this agreement. This incentive rate is inclusive of travel costs. There will not be additional reimbursements for mileage.

F. Other terms (N/A if none): No service will be provided or paid for under this agreement unless prior arrangements and approvals have been obtained from Tennessee's Early Intervention System (TEIS). The identified service must clearly be in accordance with an IFSP.

G. Vendor agrees to participate in the new state data system known as Tennessee's Early Intervention Data Systems (TEIDS) as it is developed and implemented. Vendor agrees to provide data and information as requested for Federal Child Count. The vendor will provide all required Service Log, Contact Log and Accounts Payable information directly in to TEIDS.

H. The Vendor shall document direct service sessions via TEIDS Service Log no later than 48 hours from the date of the session. Complete referral includes receipt of doctor's orders and/or TEIS payment authorization as appropriate. Failure to comply with complete data entry within specified timeline will result in non-payment of services by DOE.

I. The Vendor will enter and maintain service logs in TEIDS following each visit. The Vendor agrees to bill TEIS monthly. Payment will be made <u>ONLY</u> after the invoice, Explanation of Benefits, if applicable, and Service Log data have been received by TEIS, via TEIDS. If TEIS is the primary payer, the invoice must be submitted no more than 45 calendar days from the date of service. If TEIS is the secondary payer, invoices shall be submitted no more than 90 calendar days from the date of service.

In witness of their acceptance of the terms of this agreement, the parties have had this Agreement executed by their duly authorized representatives.

FOR Vendor:

Name

Title

Address

Telephone Number

SSN or Fed. Id. No.

FOR the Department of Education:

Department Name

Responsible Account (if applicable)

Administrative Signature (Optional)

Authorized Official

TENNESSEE EARLY INTERVENTION SYSTEM

2006 Analysis Report and Recommendations

ATTACHMENTS

TEIS STAKEHOLDER QUESTIONNAIRE 1: **CHILD FIND AND PUBLIC AWARENESS RESPONSE COMPILATION**
Number of respondents: **57**

For each of the statements below, the following was used to indicate respondents' level of agreement with the statement.

- **5 indicates Highly Agree.**
- **3 indicates No Opinion.**
- **1 indicates Disagreement**.

1. Child Find. The number of children determined to be eligible is low compared to the large number of referrals. Yet TN falls below the national average in Child Find.

	Level of Agreement
❍ The reasons for a low rate of Child Find include	
o The public does not understand Early Intervention services so many ineligible families apply.	2.6
o Some who make referrals do so even when they know the family will not be eligible, shifting responsibilities for service away from themselves.	2.3
o Families who may not be eligible are desperate for services of any kind.	3
o Child Abuse Prevention and Treatment Act (CAPTA) referrals are high volume yet CAPTA referrals are generally found not to be eligible.	3.1
o Families deny that children have developmental delays or medical problems.	3.4
o Public Awareness strategies are not optimally effective.	3.9

Comments:

- o *CAPTA referrals have been low to nonexistent in some districts.*
- o *Child Find is not the biggest problem. The reason for the low numbers eligible related to the number of referrals is the restrictive eligibility criteria in use. Our state is at the average for states with restrictive eligibility criteria.*
- o *The process is too labor intensive.*
- o *I don't feel the general public knows about TEIS. Many families are unaware of "typical" development vs. delayed development.*
- o *Providers are required to refer essentially all 0-3 therapy referrals to TEIS, even though many are likely to be ineligible. Seems most referrals are from providers, not directly by parents. Parents/physicians are not knowledgeable about EI system oftentimes.*
- o *TEIS needs a state level public awareness/training coordinator (not contracted via a university).*

❍ The reasons for a low rate of families found to be eligible include	
o Restrictive eligibility criteria.	3.9
o Inadequate eligibility assessment tools.	2.5
o Professionals performing assessment may be inadequately trained or lack skills in using qualitative measures.	2.4
o Assessments using the same tools are not performed consistently across the state.	3.1
o The system does not want additional families to serve.	1.9

Comments:

- *I think that having an assessment tool that is identified as appropriate and adequate and is used consistently by all districts across the state would definitely increase our ability to provide accurate evaluation/assessment results. It would depend upon the tool the state decided to use as to whether or not this would result in more children/families being found eligible for Part C services.*
- *While the last item listed above seems caustic, my sense is that everyone feels overwhelmed with the tasks that are currently assigned. It is not that everyone does not want additional children, it is more that everyone is too stressed to take on the challenge of finding more children.*
- *Families decline referral when told about TEIS. If TennCare is a payor, TEIS creates more paperwork and offers more obstacles to providing services such as limiting frequency and duration of therapy.*
- *Caseloads are high in certain areas and face to face contacts are demanding—it's hard to be proactive for more cases.*

- Child Find activities could be improved by
  - Dedicated staff at the Point Of Entry (POE) offices for this purpose. 3.5
  - Dedicated staff in DMRS for this purpose. 3.5
  - Dedicated staff in TIPS for this purpose. 3.4
  - Dedicated state level staff for this purpose and for Public Awareness activities. 4.4
  - More effective public awareness strategies aimed at educating
    - Physicians about services and eligibility criteria. 4.5
    - The public about services and eligibility criteria. 4.8
    - Local providers about services and eligibility criteria. 4.2
  - Closer relationships with area hospitals' newborn nurseries, NICUs, ERs. 4.2
  - Closer relationships with local DHS and DOH offices. 4.2
  - Formal linkages to autism programs and Centers of Excellence. 3.9
  - High visibility locations for POE offices in communities. 3.5
  - Better feedback to referral sources about the disposition of referrals. 3.9
  - Regular contact with likely sources of referrals. 4.2
  - Screening in community settings before making referrals to POEs. 3.9

Comments:

- *Child Find activities should be a concerted effort by POE offices in conjunction with TIPS and DMRS, and certainly with full support by the state. So having dedicated state level staff would be necessary.*
- *POE offices are district level, not local communities. Accessibility is more important than high visibility.*
- *Child Find is the responsibility of all agencies. Each agency should seek children who need services regardless of whether that agency has vacancies in the own program. Our system should see that identifying children and serving them is the need. My personal opinion is that the system has been operating under such a long list of tasks to perform that our main reasons for existence—finding children and serving them and their families—have had to take second place to the long list of administrative tasks that service coordinators and provider agencies have to perform.*
- *Need to reward frequent referral sources—public recognition—awards/publicity.*

- ❍ The state needs to implement the following Child Find recommendations from the Part C Financial Task Force of 9/05:
  - o Develop a list of diagnosed physical or mental conditions that have a high probability of resulting in developmental delays. 4.5
  - o Rely on EPSDT Outreach to help identify children with developmental delays. 3.0
  - o Develop and implement a specific plan for a homeless initiative which includes state and local coordinators. 3.4
  - o Require each POE office to designate a coordinator to work with non-English speaking families and children to ensure language and culturally appropriate evaluations. 3.5
  - o Have a child find-screening coordinator in each POE office. 3.7
  - o Use a scientific model for estimating the number of children potentially eligible for Early Intervention services on an annual basis. (Note: This is occurring through the Estimated Prevalence Study now underway.) 3.7

Additional comments about Child Find activities:

- o *Connect with translation/language resources. You could seldom find someone with the range of languages needed at varying times.*
- o *The number of homeless with 0-3 children is small—does this require a major initiative. If you can identify a funding stream to address this, I might change my answer.*
- o *A pilot project is needed in the Memphis Delta (high risk/high poverty0 to experiment with the best strategies for finding eligible children Need a special grant/funding—not necessarily run through POE, but responsive and collaborative with POE.*

1. **Public Awareness**. Many state agencies and local providers are charged with creating Public Awareness about Early Childhood services, including TEIS.

- ❍ Public Awareness activities could be strengthened by
  - o A coordinated, consistent statewide public awareness campaign. 4.6
  - o Development of a marketing plan and materials consistent across all nine districts. 4.4
  - o An identifiable name for the Early Intervention System which attracts families. 3.8
  - o Website links to appropriate services such as TN Disability Pathfinders (kc.vanderbilt.edu/tnpathfinder). 3.8
  - o Specialized public service announcements about EI services for television, radio and newspapers. 4.3
  - o Dedicated staff at the POEs for this purpose. 3.5
  - o Dedicated staff in DMRS for this purpose. 3.3
  - o Dedicated state level staff for this purpose and for Child Find activities. 3.8

Other. Specify: *Don't change the name!!!*
Comments*.*

- ❍ *They are already doing this to some extent.*

- There should be a collaborative, consistent, statewide message about Early Intervention services that includes these entities:
  - Tennessee's Early Intervention System POEs. 4.5
  - DMRS, TIPS, EIRAs. 4.4
  - Dept of Health Children's Special Services 4.3
  - Head Start 4.3
  - Early Head Start 4.3
  - TennCare 4
  - DHS Families First Services and others. 3.8

Comments:

- *While I marked all of these as very important, it may be confusing for some agencies to speak this message, since their overall purpose is not just early intervention. It probably would make more sense for a team to develop a quality message and mention the agencies that seek to help implement the mission.*

- Collaborative statewide Public Awareness activities among the agencies above
  - Would reduce duplication of effort among state agencies. 4
  - Would confuse the public about where to seek services at the local level. 2.9
  - Would not add value to Public Awareness activities. 1.7
  - Would be a good use of state resources. 4

***Other. Specify**: It is very important that we as a system focus on finding and serving children, not on filling slots. We have some Child Find activities going now, but the amount is small—hence, my hesitance for answering the items on the last indicator above.*

- The public would be more aware of Early Intervention services if POEs were highly visible in communities. 3

- Visibility of POEs makes no difference in creating public awareness about EI services. 2

- Public Awareness activities are adequate and no revisions are necessary. 1.5

***Additional comments about Public Awareness activities**:*

- *My overall comment would be that if there is a way to simplify the system so that all children birth to 3, perhaps birth to 5, are served by one entity with similar entry and eligibility criteria and expectations, etc., it would be wonderful and possibly less costly? At least we could marry all DOE funded functions and DMR early intervention programs maybe. This would be less confusing for families and providers wondering where to refer.*
- *The key is for the people working in early intervention to be making frequent contact with referral sources, regardless of the location of the POE offices.*

STAKEHOLDER ROLES identified by respondents.

_3___ Family served by TN's Early Intervention System	__3__ Therapist/Specialist
_12__ Child and Family Advocate	__2__ Physician
_11__ Provider, Agency Head	__5__ SICC Member
_14__ Provider, Direct Services	_19__ LICC Member
_15__ Provider, Administrator	_12__ State level Administrator

__4__ Other Interested Party. Specify: ____2 Project Coordinators; 2 Principle Investigators_____

TEIS STAKEHOLDER QUESTIONNAIRE 2: **ELIGIBILITY DETERMINATION and IFSP DEVELOPMENT RESPONSE COMPILATION**
Number of respondents: **66**

For each of the statements below, the following was used to indicate respondents' level of agreement with the statement.

- **5 indicates Highly Agree.**
- **3 indicates No Opinion.**
- **1 indicates Disagreement**.

1. Eligibility.

	Level of Agreement
❍ In your opinion, these factors are important for effective, efficient eligibility determination:	
o Assessments by Developmental, OT, PT, and Speech/Language Specialists individually.	3.8
o Assessments by Specialists as a Team.	4.3
o Medical assessment by a primary care physician.	3.5
o Assessment of 5 domains by a Developmental Specialist only, plus medical assessment by a physician.	3.7
o Participation of the Service Coordinator in a Team assessment meeting.	4
o Family involvement.	4.9
o Standardized, consistent assessment/measurement tools for Screening, Eligibility and Ongoing Assessments.	4.5
o Timeliness.	4.5

Comments:

- *All of these are important of course, but without real context and details these answers seem disconnected and in isolation the answers may not have validity.*
- *Don't medicalize the system. Not all children will need a medical assessment.*
- *After determining that a child is eligible, additional assessments might be helpful to generate data for IFSP development.*
- *Ongoing assessments are important when child has met goals or is not making progress toward goals.*
- *There has to be a simpler, more streamlined way to determine eligibility than the process we have now. The lack of speech language providers often slows the process – when speech-language is the area of primary concern and is determined to be the "second piece" of the eligibility determination process.*
- *Team Assessments are always preferable. If assessments cannot logistically be performed in a collaborative environment, then there must be open communication among the team (parents always included in the team).*
- *Team evaluations would be great, but generally not practical at provider level. Should be individualized based on child/family needs and provider availability.*
- *Medical assessment by a primary care physician if diagnosis is involved.*

- The most appropriate evaluation tools include
  - All of those on the State approved lists (found in Section 2, p.10 of www.state.tn.us/education/speced/TEIS/training/module7/) 3.3
  - Only a few of those on the State approved lists. 3.2
  - Some that are omitted from the State approved lists. 3.6

Other. Specify:

- *PLS – 4*
- *Peabody Motor Scales-2nd Edition; TIMP; Bayley*
- **Private providers who are not providers of services (just provide assessments)*
- *Some of the State approved list aren't used at all. The AEPS could be added.*
- *DayC seems to make more kids eligible (those who need services), Battelle Dev. Inventory 2 used in isolation has kept borderline (high risk kids) from timely services. Many end up being eligible (missing last line of comment)*

Comments:

- *This is another big question really, but the tools on the website are adequate. Some tools that are not norm referenced and standardized are good tools, but we don't use them for eligibility. The field is rich with information about how to assess young children and we can definitely review what's available and useful. Of course what you plan to do with the information from the tool dictates its appropriateness.*
- *Project START behavioral assessment*
- *Idealy, the assessment instrument should help determine eligibility and provide information for IFSP development.*
- *A number of the measures on the list have been renormed recently.*
- *Ideally, evaluations should be performed by an independent evaluation team who have demonstrated competency in performing assessments and interpreting assessments on a wide variety and age of children.*

- Evaluations for eligibility determination are best performed by
  - TEIS, TIPS, EIRAs and DMRS agencies, whichever is thought to be appropriate by the Service Coordinator. 4.3
  - TEIS only. 1.9
  - TIPS only. 1.6
  - EIRAs only. 1.6
  - DMRS only. 1.7
  - Children's Special Services. 1.8
  - Private Providers. 2
  - State funded teams in POEs. 3.5
  - None of the above. 1

Comments:

- *Once again it's really hard to answer this in the context asked since its isolated. Fundamentally, eligibility is likely best served by one entity to ensure reliability of testing etc. TEIS is a single point of entry and so it makes fiscal sense, content sense and system sense to have that under TEIS at the district level.*
- *Too medically based*
- *Any one of the "only" choices are too restrictive.*
- *Service Coordinators who have backgrounds that are appropriate. If local teams are to be used, it would be more cost efficient to develop multiple teams in each region so that most of the funding is not eaten up with travel time.*
- *Children's Special Services should only determine eligibility for the CSS program.*
- *Whoever completes the evaluation needs to have a great working knowledge of child development. I feel that not any one person could rule out difficulties in all areas.*
- *It would be very helpful to have a readily available team – that had no vested interest in being the service provider and who could do the eligibility determination very quickly.*

❍ The state should utilize OSEP Policy Guidance which states that assessment in the 5 domains by a Developmental Specialist plus a medical assessment meets the Part C requirement for multi-disciplinary assessment. 4

Comments:

- *I can't answer this as written because I cannot ascertain the context of this guidance. I really don't know enough about the implications here to venture an intelligent answer; I can say that streamlining eligibility criteria may seem right on the front end but may cause a horrendous number of problems because it will send so many children into the system that it would be financially reckless…and this is the place to say that when you serve a high number of at risk children with minimal delays, the bulk of the money can so easily go to this population.. arguably because they have more potential than the severely delayed child, and the more involved or delayed child gets less.*
- *Is a medical assessment always necessary? I don't think so. Please don't require medical assessments for ALL children, only as necessary for a particular condition.*
- *We currently use up too much $ and too much time on assessments.*
- *What qualifications would a Developmental Specialist have?*
- *I'm not sure whether the second discipline would always need to be a medical assessment.*

❍ Current eligibility criteria of 40% delay in one developmental area or 25% in two areas

- Are appropriate. 2.8
- Are too restrictive. 3.7
- Are one reason for the low number of families determined to be eligible relative to the number of referrals. 3.9
- Should permit children with 20-29% delay in one area. 3.5

- Should permit children with 30-39% delay in one area. 3.8
- Should match DMRS criteria of 20% delay in one area. 3

Other. Specify:

- *Look at other measures beside solely AE (e.g., standard deviation, etc.)*

Comments:

- *I have found this definition very discriminating over time…I did not like it initially…It really seems to identify the children who are disabled vs the children who are environmentally deprived and not achieving due to poverty, etc. We do serve some of those children but only those the most dramatic of life situations…that's been good. We should never take lightly labeling a child as disabled, even from birth to three. The law is written to serve children with disabilities, not those of normal intelligence who have had deprived opportunity. Headstart and perhaps other different state resources should accept fiscal responsibility for this population in general.*
- *Should take into consideration needs of child and family – for example – child with slight delays in home environment with no stimulation plus M.D. recommend then should be eligible.*
- *Could we afford wider eligibility? If resources are available to fund this, then wider eligibility could be a good thing.*
- *I don't' know the right answer, but the wrong answer is, "Your child doesn't qualify now, but let's test him again in a few months to see if he is more delayed." If we are going to err, let's err on the side of serving the child.*
- *DMRS needs to change standards of eligibility criteria to at least 25% in two areas.*
- *DMRS/TEIS should "match" in the future.*

❍ It is important for evaluations for eligibility determination to be reimbursable by **NOTE**: BAD INFO; ERROR ON QUESTIONNAIRE.

- TennCare. [2.1]
- Cover Kids (State Children's Health Insurance Plan—SCHIP). [1.9]
- Private insurance. [2.9]
- None of the above; it is an entitlement. [1]

Comments:

- *Again, I cannot answer this intelligently without a little more information. This is truly a loaded question. And while I can see utilizing all payor sources is important to the fiscal soundness of the system, I know robbing peter to pay paul is not an effective intervention.*
- *Parents should use their private insurance as that is possible. Are all developmental delay problems covered by these medical reimbursement systems?*
- *All of the above.*
- *It is appropriate to access funds if appropriate if they do not delay the process; however, it should not be a requirement.*

1. **IFSP Development**. There are many requirements for IFSP development relative to participation and timelines. There are currently a range of processes in place to meet the requirements that are not uniform statewide.

- ❍ The most logical, practical trigger for the 45 Day Timeline for IFSP Development is when
  - o The referral is made to TEIS. 2.9
  - o Initial contact is made with the family. 2.6
  - o Intake occurs. 3.3
  - o The family agrees to eligibility determination process and is informed of their rights. 3.2
  - o Eligibility is determined affirmatively. 2
  - o None of the above. 1

Other. Specify:

- o *There should not be a loophole that the 45 day timeline will begin with initial contact as this can significantly delay the process. However, should be some stipulation that initial contact with the family will be made with "X" number of days of the referral. If the SC cannot contact the family within that set amount of days, then the person making the referral will be notified so that the process can re-start.*

Comments:

- o *Sometimes the process is rushed to meet guidelines; further assessments may be beneficial to help develop comprehensive IFSP, but not done due to not needed for eligibility purposes.*

- ❍ It is desirable to develop the IFSP at the time the family is determined to be eligible. 3.5

- ❍ Developing the IFSP when eligibility is determined would require
  - o The entire assessment team to be convened at the same time. 3.4
  - o An extended period of time on site with the family. 3.8
  - o A prohibitive amount of time on site with the family. 2.8
  - o Having service guidelines in place. 3.9
  - o Knowing in advance what services the project coordinator would authorize. 3.2
  - o Knowing available service providers in advance. 3.7
  - o A change in TN regulations. 3.8
  - o Implementation of TEIDS. 2.8
  - o All of the above. 1.8

Comments:

- o *I think it would be very difficult to capture families for this period of time and it would very often be a burden to the family who needs time to digest the information from the evaluation. It seems like the service coordinator would have to have a low caseload to dedicate this length of time per family.*

- *Something that has just come up that I did not mention on the Questionaires regarding IFSPs – In my opinion, TEIS should be a part of the initial IFSP if the child is found to not qualify for TEIS but does qualify for another agency. Hopefully, this will b a moot point when changes are made to the system-a child will either qualify or not qualify regardless of the program.*
- *I work in a DMR program. In our area, our TEIS service coordinators usually are a part of the initial IFSP even if that child qualifies only for our program. Recently, the TEIS service coordinators were told that they are not supposed to be a part of that IFSP-they drop out when the child is determined to not be eligible-and that IS what the regs say-we just hadn't been doing it that way. If a child does not qualify for TEIS but does qualify for another program, the TEIS needs to be sure that that referral is made and followed up on. If they stay active until that initial IFSP, that would be easier to do.*
- *The IFSP should be developed by a team, not just the service coordinator and the parent. The contents of the IFSP should be based on child and family needs.*
- *You can't separate educational and medical services completely – they are inter-related.*
- *I think it might be overwhelming to the family to find out about eligibility and develop an IFSP at the same time.*
- *I do feel the interim IFSP is very under utilized particularly with those families whose children automatically are eligible based on diagnosis or prematurity guidelines.*
- *Do not agree with doing both – very impractical; overwhelming for families; lack time to process information and make best decisions possible.*

❍ For the families served by TEIS and CSS it is desirable for one plan to be both the IFSP and the Family Service Plan (FSP) relative to medical services such as OT and PT. 3.9

Comments:

- *This sounds like a good idea on the surface but it is difficult to achieve a combined form or attachments, and the data systems between departments would have to be compatible.*

❍ Advantages to a common IFSP/FSP plan for medical services include:

- Reimbursement for OT, PT and other medical services from the most appropriate payor. 3.6
- Authorization for medical services by qualified medical personnel in CSS. 3.5
- Ensuring EPSDT screens are completed. 3.6
- Local CSS offices have existing relationships with pediatric health care providers such as OT/PT in all communities. 3.9
- Ensuring services continue when a family is no longer eligible for Part C program but the medical needs continue. 4.6

Comments:

- *If we were only providing medical it would be a better fit. We are charged with developmental services which is very holistic.*
- *No knowledge base for responding to these choices.*

- ❍ Obstacles to developing a common IFSP/FSP plan for medical services include:
  - o A level of communication between POE Service Coordinators and CSS regional offices that does not currently exist. 3.5
  - o An extra step in the process for Service Coordinators in developing IFSPs timely. 3.4
  - o CSS and Part C are separate systems at the state level, although from a federal perspective the programs are meant to complement each other. 3.9
  - o The perception that to form such a relationship successfully is burdensome. 3.3
  - o That it requires a central billing process that does not currently exist. 3.2

Comments:

- o *This question and the bullets seem to assume there is not a positive relationship with CSS, and while that may be true in some districts, our district has a very strong relationship and we work very effectively together, so it would not be bothersome and we already do this. The mandates of the two programs are different and interface on some fronts. I would say that we serve about 8-10% commonly so how much mileage would you get out of the idea of two different IFSP forms, and how confusing would that be for the 92% of the other children.*
- o *I am unaware of the relationship between CSS and TEIS. To be eligible for CSS, children must qualify under financial and diagnosis guidelines; therefore, disqualifying a large number of children who are TEIS eligible.*

STAKEHOLDER ROLES identified by respondents.

__3__ Family served by TN's Early Intervention System	_7___ Therapist/Specialist
_10__ Child and Family Advocate	_____ Physician
_14__ Provider, Agency Head	_4___ SICC Member
_19__ Provider, Direct Services	_22__ LICC Member
_28__ Provider, Administrator	_7___ State level Administrator

__7__ Other Interested Party. Specify: 2 Principle Investigators; 1 Project Coordinator; 2 TEIS Svs Coordinators; 2 CSS Care Coordinators

TEIS STAKEHOLDER QUESTIONNAIRE 3: **INTERDEPARTMENTAL PLANNING and SERVICE COORDINATION**
Number of respondents: **37**

For each of the statements below, please indicate the extent to which you agree with the statement.

- **5 indicates Highly Agree.**
- **3 indicates No Opinion.**
- **1 indicates Disagreement**.

1. Interdepartmental Planning. Multiple groups are planning about Early Intervention services including DOE Part C required SICCs and LICCs; DOH lead ECCS federal planning grant; Head Start Advisory Councils; Developmental Disabilities Planning Council for DMHDD.

	Level of Agreement
Interagency planning is essential for building strong Early Intervention systems.	4.4
These Interagency Planning groups are unique and each has observable outcomes from their processes.	
o SICC	3.4
o LICC	3.4
o ECCS	2.7
o Head Start	2.1
o DD Planning Council	2.8
o Special Education Planning Council	2.7

Other. Specify:

- *Dept. of Ed. State Improvement Grant (SIG)*

Comments:

- *This is a literacy based personnel pre grant but is concerned with per-literacy skills in very young children.*
- *I really have no knowledge of what these agencies do. I have only recently assumed this position and I have not yet attended any of these meetings.*
- *Not sure what ECCS is and how they support EI.*
- *I don't know very much about the other groups' activities.*
- *Participation in LICC has not been particularly beneficial. SC region has no interagency agreements.*
- *Have never heard of ECCS!*
- *Unsure about SICC, ECC, DD Planning Council, and Special Education Planning Council due to lack of personal involvement.*
- *Do not have knowledge of ECCS in TN to respond. Have not experienced Head Start, DD planning Council, or Special ED Planning Council Groups as related to early intervention in TN therefore unable to respond to them in the context of this.*
- *Within some regions, service coordinators and providers meet regularly to share information and address individual issues*
- *Interagency must be addressed at the district level….where the rubber meets the road at implementation.*
- *Too many cooks spoil the soup. Just get it done*

- ❍ The Planning groups are more duplicative of each other than they are distinct from each other. 3

Comments:

- o *Most of the groups seem to relate to special ed, with the exception of Head Start.*
- o *The SICC is a nice networking opportunity and forum for status updates, but rarely engages in planning or coordination activities. The LICCs are similar. ECCS is navel gazing, quite honestly, accomplishing little if anything.*
- o *Parent participation is encouraged and parents are represented; however, this is not the best arena to hear from families.*
- o *Unsure due to lack of knowledge about several of the agencies.*
- o *See comment above.*
- o *I don't understand the question.*

- ❍ In your opinion, benefits of the SICC include
  - o The Council meets requirements of Part C federal laws. 4
  - o The Departments seek input from the Council on important issues. 3
  - o The Council influences policy decisions effectively. 3.1
  - o Interagency communication occurs and the EI system is enhanced. 3.3
  - o Issue oriented problem solving occurs in the Council. 3
  - o Cross fertilization of ideas takes place. 3.4
  - o Resources are identified that assist your area. 3.1
  - o It is a method of staying current on policy issues. 3.5
  - o It is a good forum for getting input from families. 2.4
  - o Discussion is based on relevant research and evaluation data. 3.3

Other. Specify:

- o *Great opportunity to promote our services for families and enlist agency assistance in recruiting family participation in survey activities.*
- o *I almost always attend as an observer to try to keep abreast of changes; communication only trickles down slowly to the rest of us.*

Comments:

- o *It has been a struggle to get the Council to discuss and make recommendations on real issues except in the past 2 to 3 years due to work groups and committees being formed. Prior to that, all issues were solved by the Early Childhood Coordinator. The SICC was only used as a "show and tell."*
- o *Not directly involved with SICC.*
- o *I don't think a lot of EI people at the local know much, if anything, about the SICC.*
- o *Everyone feels included in LICCs. Tasks are shared and partnerships occur. The downside is that sometimes the agencies that need to make changes do not participate. Then, in the past, when it has been time to write the LICC community plan, the agencies who are seeking to follow the spirit of the law are left with responsibility for making changes that are outside their preview.*

- *It's useless, and only meets the Federal requirements.*

  - The limitations of the SICC include
    - The advisory role of the Council has no authority. 3.4
    - The Council is more for "Show and Tell" than problem solving. 3.6
    - Participation is inconsistent. 3
    - Lack of participation by decision makers. 3.2
    - Meetings are too infrequent 2.5

Other. Specify:

- *Location*
- *The SICC has never fully complied with federal requirements for having family participation. Families are recruited to the SI not given appropriate supports and accommodations to facilitate attendance or involvement in other ways.*
- *We certainly need to have more decision makers at the table, also these groups mentioned above3 could certainly be better coordinated.*
- *The SICC retreat held 2 years ago was very helpful in developing a long range plan for issues with measurable outcomes bu was difficult to keep the momentum.*
- *Not representative of all stakeholders in a collaborating context/atmosphere. No use of working committees charged by SIC gather info, report and info decision making. Agenda is rarely related to relevant issues at hand and never related to planni future. Not an energized or energizing group to date, potential to be one, however, is great.*

Comments:

- *I wish the SICC would utilize videoconferencing technology to open the meetings to parents and others in more remote or di locations. Also, the council is too rigid in its meeting schedule. Tuesdays from 9 to noon is not ideal for family attendance. about an evening meeting once in a while. I am pleased that the council has made some effort to hold at least one meeting of Nashville each year. That took some doing. It's a wasted opportunity as far as public or parent participation is concerned.*
- *DMRS agencies never hear about how they impact. Minutes are not distributed.*
- *If truly used as a group of advisors, the benefit would be greater.*
- *Not directly involved with SICC.*
- *I attend most SICC meetings because I've found it to be a good information dissemination venue for EI and offers a way for keep up on what is happening in EI at the State level. But it does not seem like the council has any advisory role. I also don many of the "members" of the SICC are involved.*

  - The benefits derived from the SICC outweigh the limitations. 3.3

Comments:

- *I and my program get more benefit from these forum opportunities than benefits the TEIS planning efforts.*
- *They are a group that seems very far off and unreachable.*

o

- *As currently operated, no. But potential to have major benefits is great.*
- *It is required by law and it presents the framework for statewide collaboration and problem solving.*

- The benefits of the LICCs include

The Council meets requirements of Part C federal laws.	4
Provision of input to the SICC on important issues.	3.2
Interagency communication occurs and the EI system is enhanced.	3.6
Better coordination of all early childhood services at the local level.	3.3
Issue oriented problem solving occurs in the Council.	3
Cross fertilization of ideas takes place.	3.1
Resources are identified that assist your area.	3.5
It is a method of staying current on policy issues.	3
Discussion is based on relevant research and evaluation data.	2.7
Inclusion in Continuous Improvement Monitoring Process (CIMP).	3.6

Other. Specify:

- *If everyone attended and actively participated with a focus on issues at hand, this group could be very useful to district and SICC rarely asks LICC for information. LICC meetings are sometimes allowed to become forums for individual providers ag Leadership in the last 2 years has made significant impact on collaborative atmosphere, clear agendas and more careful pla with all working committees to stay focused on the issues for early intervention system in the district.*
- *I tried to answer as a group, as I try to attend 3 different district LICCs and they all operate differently.*

Comments:

- *I don't attend these but occasionally my staff do.*
- *This is where CIMP is addressed mainly.*
- *In this district the LICC has become stronger because the day was changed to coincide with monthly providers' meetings tha held. Really, more communication, problem solving and coordination of early childhood services at local level occur during monthly provider's meeting than the LICC meeting.*
- *Too much of the LICC's time has been required by the CIMP/APR process – but it has forced community members to work to who might not have otherwise. Some research information has been shared but the available time has been limited by othe requirements.*
- *The primary purpose of the LICC has been to meet requirements of CIMP.*
- *The East TN LICC is a very active group but other LICC's may not be the same. The SICC developed a plan to get LICC's involved in reporting at the state level but many LICC's didn't see benefit form the SICC – there was a feeling of disconnectio SICC has no authority; made no decisions; discussed no important issues that would help LICC's).*
- *I suspect GNLICC has an advantage because more State level people are apt to attend meetings.*
- *This is the same as the information prior.*
- *Too controlled by TEIS.*

- *Therapists are only ones who do not attend.*

❍ The limitations of the LICCs include

o It is difficult to get representation from all relevant entities.	2.6
o It is difficult to get family participation.	4
o Lack of organizational structure (officers; agenda; procedures).	3
o The Council is more for "Show and Tell" than problem solving.	2.7
o Participation is inconsistent.	2.7
o Lack of participation by decision makers.	2.7
o Meetings are too infrequent.	2.1

Other. Specify:

- *Location*
- *LICC activities are not reported up the pipeline for sharing at SICC meetings.*

Comments:

- *The meetings are held quarterly and it is extremely difficult to get parental involvement and decision makers are not always available.*
- *Again, the East TN LICC is very active and has great participation. It is a model for all other LICC's.*

❍ Early Childhood Comprehensive Systems (ECCS) is funded to plan across agency lines.

o Part C/TEIS related planning is compatible with ECCS requirements.	2.7
o All planning groups listed above should be represented under an ECCS planning umbrella.	2.7
o Departments/agencies would likely participate in a comprehensive planning process lead by ECCS.	2.7
o It is feasible to develop such a comprehensive structure.	2.7
o Comprehensive planning under ECCS would be too complex to warrant the effort.	2.3
o I am not familiar with the ECCS planning process.	3.9

Other. Specify:

- *This has been a lot of disjointed "blue sky" activity not connected to any implementation strategies.*
- *I am not fully informed about ECCS in Tennessee.*
- *I have been involved with the Early Intervention System since inception (~1987) and have never heard of this!*
- *I have no idea what this is.*

Comments:

- *N/A - Not familiar*
- *Forgive my ignorance, but I am not familiar with ECCS and what the goals of the project are. Not able to answer questions above.*

- *I don't know enough to respond coherently.*
- *Unfamiliar with ECCS.*
- *I don't recognize this by this name so I cannot make a valid comment.*
- *Never heard of it - says a lot doesn't it!*
- *I have never heard of this group before. Should there only be one statewide planning council for all or both?*

❍ The potential benefits of consolidated planning include

Increased visibility for children's issues.	4
Increased functional interagency planning.	3.9
Reduction in duplicative staff functions for planning.	3.3
Efficient use of family, consumer and advocacy input.	3.6
Increased likelihood of coordinated, comprehensive Child Find and Public Awareness activities.	3.8

Other. Specify:
- *Takes training, support, and time to build consolidated planning teams/collaborators to achieve this mission.*
- *There is a lot of duplication going on and little communication between depts.*

Comments:
- *This is necessary.*
- *In theory, sounds like an efficient use of funds! However, would want to know specifics to determine how beneficial consolid planning would be for early intervention.*
- *Theoretically, all these benefits seem possible.*
- *Define what is meant by consolidated planning.*

❍ Limitations of consolidated planning include

Loss of identity for individual planning groups.	2.9
Complexity of meeting all federal planning requirements.	3.2
Consistent participation from all stakeholders.	3.2
Legitimate roles with identifiable responsibilities may be hard to establish.	3.3
Lack of accountability for specific agency-based planning requirements.	3

Other. Specify:
- *Location*
- *If one group can meet many needs, the attendance will likely improve. We are always criss crossing at similar meetings.*

Comments:
- *Regardless of participation in a state-wide organization, agencies are still accountable for their individual programs.*
- *I don't recognize this by this name so I cannot make a valid comment*

1. **Service Coordination.** Part C laws require coordination of all Early Intervention services statewide, across agency lines. For the purpo
the following questions, the agencies and services are those of Office of Early Childhood, DMRS, DOH, TennCare, Head Start; TIPS, CS
agencies.

- In your opinion, services are well coordinated at the State level, evidenced by
  - Shared values among all state agencies involved in the EI system. 2.7
  - Clear, open lines of communication among the agencies. 2.2
  - Observable partnerships and alliances that benefit families. 2.8
  - Collaboration on policy development. 2.6
  - Collaboration on funding issues. 2.1
  - Few gaps in services. 2.1
  - Services are not duplicative of each other. 2
  - All parties share relevant management information. 2

Other. Specify:

- *Every TEIS district operates differently, sometimes even Service Coordinators within a district operate differently, it is hard t*
imagine there could be such inconsistency, but it exists daily and hurts all parties involved and families and children.

Comments:

- *DMRS has Gayle that is vocal and supportive, Part C has been seen as this entity that makes all rules with no discussion.*
- *The system is clearly disjointed.*
- *The system at the State level is <u>much</u> better that before TEIS.*
- *I am most aware of coordination between DMR and DOE.*
- *I just don't know about service coordination at the State level.*
- *Coordination can be bolstered at the state level to help support the implementation at the district level. I said that to say this*
real coordination happens through trust building at the district and county level, through strong leadership at the district POE
- *It's a mess – there is no coordination.*
- *TEIDS is really going to help!*

- In your opinion, services are well coordinated at the regional/local level, evidenced by
  - Shared values among all local providers involved in the EI system. 3
  - Clear, open lines of communication among providers. 2.9
  - Observable partnerships and alliances that benefit families. 3.2
  - Collaboration on service coordination. 2.9
  - Few gaps in services. 2.8
  - Services are not duplicative of each other. 2.5
  - All parties share relevant management information. 2.4

Other. Specify:

- *If only TEIS enforced their own rules and regulations and held their own TEIS district offices accountable, we would perhaps some consistency and "meeting of the minds". I am so tired of hearing DMRS ahs a conflicting set of regulations, DMRS jus enforces IDEA and monitors compliance. This is evidenced by the high consistency rate between DMRS programs vs. the h inconsistency rate between TEIS district offices.*

Comments:

- *I believe at time that a family does need both family training and special instruction. I have never agreed that TIPS, EIRAs, are duplication of services. At least not in this region.*
- *Locally with TEIS things run well, regionally not so much. Major gaps in related services and much duplication regionally.*
- *I believe each district is different but it is a result of the district leadership. My comments are more valid relative to the UC s is the district I am most familiar with.*
- *Better local, but only because so few service agencies.*
- *Still not a clear understanding with some agencies, routines based intervention vs. more traditional intervention although ver being done by TEIS locally due to overload*

❍ Duplication of effort is occurring relative to

o Child Find	3.3
o Eligibility Determination	2.8
o Family training	3
o Special instruction	3.1
o In-home visits	3
o Service Coordination	2.7
o Program administration	2.5
o Similar services that are called by different names.	3.6

Other. Specify:

- *"Duplication of effort" raises a red flag for me. I fear duplication being replaced by little or no effort.*
- *Duplication because of lack of clear policies/procedures and quality training/education for all working in the early intervention system. Duplication because of too many different administrating agencies with competing agendas that do not always mat C of IDEA.*
- *DMRS has always provided family training service for over 30 years, suddenly DOE decided only TIPS can provide that serv is very important to pair special instruction with family training.*

Comments:

- *A child enrolled in Early Head Start also gets services from TIPS, TEIS, Service Providers - so may have duplicate family tra home visits.*
- *I don't know if it is duplication if each program has its own administration.*

- Face to face visits occur monthly. 3.5

Other. Specify:

- *Service coordination is most effective when it avoids the pitfalls of co-dependency, whereby the service coordinator fails to encourage family decision-making and empowerment, which makes for a very difficult transition from EI services to presch Part B services*
- *Clearly established policies and procedures and education/training supports and resources are pivotal factors of effective se coordination. A Comprehensive System of Personnel Development (CSPD) for all working in provision of early intervention services is needed.*
- *The problem is in many rural counties the TEIS office is hours away, long distance by telephone, and the Service Coordinat "covers that county" (not much choice there) only visits the county every other week or so families don't have easy access to service coordinator, yes, there is a 1-800 number, but that isn't really easy for families. I have been around since the beginn Part H/C and we really used to emphasize families could CHOOSE their service coordinator and that just does not happen anymore at all. TEIS service coordinators (mostly) do not receive appropriate training or mentoring and o not have a good understanding of the system.*

Comments:

- *Families get lulled into complacency that there will always be someone looking out for them and holding their hand through various developmental stages unless the service coordinator takes care not to make herself indispensable to the family.*
- *If we have to be computerized, it had better be "user friendly". As providers, we are more interested in the family receiving services than completing a lot of repetitive paperwork. If the service coordinator is not a direct-care provider, it is likely that coordination could be handled over the phone.*
- *Service Coordination should be provided locally by people with knowledge in early childhood or family studies and experienc*
- *In this district office, we have created an administrative system with lines of supervision for all staff and wrote in house polic procedures. Mentoring is conducted with more experienced staff and yearly performance evaluations are completed per the mandate from the University. This office also enhanced the Filemaker system to become more user friendly and ensure the efficiency of the office is maintained. All this has aided in our raising the percentages of meeting federal and state mandated timelines. We are not at 100%, but a lot closer than we were 3 years ago. Working on ways to continue the efficiency in hou related to TEIDS.*
- *For some families face to face monthly visits are a burden and productive interaction can be done by phone…some families need a higher level of face to face…however, the face to face monthly visit does give us a chance to get to know families bet their own environment.*
- *Whoever is in frequent contact is in best position for SC.*
- *Mentoring is very important – needs to be ongoing.*

❍ Service Coordinators should serve

- No more than 60 families. 2.2
- No more than 50 families. 2.4

No more than 40 families.

- *Duplication happens most with TIPS and DMRS also between Service Coordination from TEIS and the DMRS provider.*
- *It is amazing how many providers provide informal service coordination to families rather than allowing the IFSP team discus options available. Families "shop" for services based upon a therapist's recommendation, or a provider's recommendation. training and special instruction are "cloudy" related to roles.*
- *Family Training and Special Instruction continue to not be well defined, leading to in-home visit and community visit duplicat and/or gaps in services.*
- *The provision of "Special Instruction" is not well-coordinated. Special Instruction and Family Training often overlaps.*
- *I've recently concluded the concern around duplication of effort has led to significant confusion around special instruction an family training, with the two being perceived as two separate services that are provided by two different agencies (i.e. TIPS family training and DMRS does special instruction). As a result, an effort is made to provide an eligible child with <u>either</u> spec instruction <u>or</u> family training (but not both); and thus either TIPS or DMRS (but not both). Part C, however, does not make su distinction, defining both as special instruction and family training as a service that supports families. Likewise, both DMRS outreach and TIPS define their program as providing both special instruction and family training. Thus, this duplication of ef issue around home-visits seems related to a faulty interpretation of the Part C definition. Because Part C funds are not to be when another agency can pay for the service, it seems the clarification can be linked to funding for these services. To provi support for the need to clarify this policy/practice, I note our DMRS agency has had openings in our community outreach for year and monthly reminders to TEIS of the need for referrals has not resulted in more referrals.*
- *Different services that are called by similar names!*
- *I don't know what is meant by the last bullet…in the UC we have made clear distinctions on these services…some are valid distinctions and some are contrived to fit the payor framework. DMRS and TIPS have very different personnel and training programs…paraprofessionals in DMRS are still being used for intervention. I believe there is a case to be made for all EI per to be degreed in the early childhood field or an ancillary field…like speech, etc. We need all our providers and we believe all providers are working hard at providing quality services…some are just more prepared than others.*
- *Again, few services available.*
- *Most programs are doing this differently. Some with just handouts, some with modeling in routines based intervention.*

- Service coordination is most effective when
  - District offices have staff with diverse educational, knowledge, experiences, backgrounds. 3.6
  - There is one service coordinator throughout a family's period of service from intake through conclusion. 3.9
  - User-friendly data systems. 4.1
  - Quality administration evidenced by
    - Leadership 4.2
    - Clear lines of supervision 4.4
    - Established policies and procedures which are applied uniformly. 4.5
    - Mentoring. 4.3

Performance evaluations.

No more than 30 families. 3.1
- The number of families based on complexities of the families. 3.2

Other. Specify:
- *This is an oddly worded question and difficult to answer. I would think that 30-40 families would be enough, but it depends on the complexity of the families.*
- *Depends on the expectation/'duties. If the job is data entry and filling in forms, it may mean that the number of families assigned is meaningless. If it means getting to know the referral sources and having regular and frequent contact with them while having monthly (important content) meetings with families, then a more reasonable ratio is required. The key issue is: Are we asking service coordinators to coordinate services, or are we asking them to just be data entry people. I know our system is in a state of change, and I personally feel that we are moving in a better direction, but the emphasis should stay on the services that families are receiving, not on whether an individual is overloaded. Further, we need to do a "bare bones" look at what is legally and professionally required for service coordination to be effective. I believe that we have been asking services coordinators to do many tasks that may not fall under the definition of "service coordination" that we eventually agree upon.*

Comments:
- *I really have no idea how many families TEIS service coordinators now serve. As a service provider, I get overwhelmed with the paperwork when I start getting over 15 families (and I am service coordinator for most, if not all). I had twenty-five families at one time and that was TOO many!*
- *Families have many needs and they cannot be addressed if the SC has too many cases.*
- *To meet federal and state mandated times, the caseloads must be reduced. Right now, we are shuffling paperwork and not really "working" with the families as service coordinators should be doing. TM is wonderful and allows service coordinators to really work with families in theory, but until the caseloads are lowered, not all families are being seen monthly and are not benefiting from what our service coordinators can offer them.*
- *I support the model where service coordination is part of service provision and done by the provider agency, not the designated service coordinator used here.*
- *All families are complex…no more than 40 gives a chance to be meaningful to the family as you have more opportunity to develop trust and affect change.*
- *Don't kill the coordinators; don't let services fall in cracks.*

❍ Family friendly service coordination is characterized by
- Respectful interaction with the family. 4.8
- Completing forms. 3
- Assuring families have a clear understanding of service options, choices and also 4.8

any applicable rules.

- Granting every request of the family. 1.9
- Interacting with the family in the minimum amount of time possible. .03

Other. Specify:

- *Understanding of the family specific routines, traditions, priorities, and concerns. This understanding can only come with the HEARING of the Family Story, asking relevant questions, and helping the family identify their priorities/needs.*
- *Clearly explaining scope of services to families and IFSP team members to understand who and how supports/services can be provided.*
- *There are too many forms for families to have to deal with, not family friendly, even Part B has less forms.*
- *Let's not lose family needs in our haste to save $.*

Comments:

- *Some families require more support and TEIS has provided minimal support. DMRS offers more comprehensive support.*
- *It's all about relationship and trust.*
- *Not sure what is meant, efficient or little contact.*

1. **Training.** Training was described as "woefully under funded" by national experts who reviewed TN's EI System during the Spring 2006. In your opinion, approaches to improve training capacity include:

❍ Interagency collaboration and funding of shared training.	4.5
❍ Cross training among all programs providing in-home services.	4.3
❍ Requiring coordinated, consistent, evidenced-based training curricula of all direct service providers.	4
❍ Working with higher education to develop and promote training for Early Intervention Specialists, birth to 5 for Special Education and regular Education professions.	4
❍ A training coordinator at the state level to be held accountable for establishing and executing a uniform training plan statewide.	4

Other. Specify:

- *A clearly defined CSPD, with all Stakeholders participating and a system of delivery for training by qualified, smart, creative, knowledgeable teams, including families, will be useful to consider in place of holding a training coordinator accountable at the state level.*
- *The brand new service coordination training modules are awful. And they were not implemented consistently across the state.*

Comments:

- *We recently completed 10 modules of Service Coordinator training. It was a true waste of time–it was feel good, ideal world training with a spattering of useful information thrown in. Since everyone has different skill levels, there is no "one size fits all". What we need is uniformity of developing IFSPs, including clear guidelines for writing measurable outcomes. If TEIDS is going to be a part of our world, then the providers and non-TEIS service coordinators need training. We also need practical information on day-to-day, hands-on activities about dealing with sensory integration, autism, classroom activities, etc so that we can stay up-to-date and can pass information along to parents. We don't need "how to be a nice person" training. If your personality does not fit this job, you will soon quit or be fired.*
- *Highly needed and way overdue!*

❍

- *The wording of this question is confusing. I answered based on what SHOULD be included in training.*
- *For the last point - I'm not sure one person could handle this huge task.*
- *There are no consistent guidelines for "qualified providers" of early intervention services.*
- *Training is a very important and we do a lot of cross training at the district and county level…*

STAKEHOLDER ROLES. Please check all the roles in which you serve.

3	Family served by TN's Early Intervention System	2	Therapist/Specialist
10	Child and Family Advocate		Physician
11	Provider, Agency Head	8	SICC Member
6	Provider, Direct Services	14	LICC Member
15	Provider, Administrator	8	State level Administrator

6 Other Interested Party. Specify: _____

THANK YOU for completing this survey. Return it to Mary.Rolando@state.tn.us

TEIS STAKEHOLDER QUESTIONNAIRE 4: **DIRECT SERVICES**
Number of respondents: **39**

For each of the statements below, the following were used to indicate respondents' level of agreement with the statement.

- **5 indicates Highly Agree.**
- **3 indicates No Opinion.**
- **1 indicates Disagreement**.

(1) Natural Environments. Concern has been express about the State's compliance with Part C's Natural Environments (NE) requirements. This is not unique to Tennessee, but it is cause for concern.

	Level of Agreement
❍ The family's home is the primary place where services should be provided.	3.08
❍ The following positive NE characteristics are routinely evident in the State's EI system:	
o Informal support occurs during family routines, as well as parent training, which produces successful results in children and families.	3.92
o Work is done with children in classroom settings like day care rather than removing them to a therapy or instruction room.	3.90
o Care-givers follow children's cues rather than performing structured, repetitious drill work.	3.77
o Care-givers integrate developmental interventions into daily routines.	Data Error
o Families are given sufficient information and skills to act independently in seeking services.	3.51
o IFSP Goals are stated in functional terms (sitting, eating, drinking independently; playing with toys), not professional jargon.	3.44
o The purpose of home visits is to consult with the parent rather than provide direct instruction to the child.	3.08

Comments:

- *I think it's important to keep in mind the Individual in IFSP. Different settings work better for different children. Some goals are easier addressed alone with child while others can easily be incorporated in to a classroom/daycare setting. Lots of two year olds attend daycare or preschool.*
- *The purpose of the home visit is to model for the parent the manner in which they can incorporate skills with their child into everyday activities. The parent's input should be valued during this time.*
- *For most families, the primary purpose of the visit is to work with the child to increase skills. Consulting with the parent is also very important for continuity of developmental activities when the provider is not in the home and for emotional support of the family.*

Most of the therapists in the Project HELP center know to work with the children in the inclusive classroom setting. The therapists often serve as a one-to-one assistant for the child during the classroom therapy sessions. Unfortunately, often times

- *the families are not given complete information in choosing and/or seeking services; information is often given according to who the payer will be.*
- *Parent instruction is multifaceted, depending on the needs of the family. Some working parents have stated they prefer for their child to be in a setting with typically developing peers while their involvement is occasional interaction with staff for updates, feedback, new information, etc. Other parents prefer the parent instruction in the home.*
- *It's possible that some of the approaches described above could be less appropriate with a child with autism spectrum disorders, who might in fact learn best through highly structured, repetitive interventions. I've heard some frustration from families over the limits on ABA-type services. In answer to #1, for some children, a child care center might be in fact their natural environment during the day rather than the home.*
- *The child's NE is not always the best environment for direct services nor is it always positive. There is nothing wrong with providing a more positive environment and in turn helping the parent and showing them that they can make their environment more positive.*
- *A home is sometimes the best place for service delivery and sometimes not.*
- *Home visit should allow for both direct instruction and parent consultation, as appropriate.*
- *Home visits need to be a combination of demonstration, showing parents how to use toys/materials in their home and how to implement in daily routines. In order to be successful, the home interventionist needs the skills and experience to understand the developmental skill before teaching the parents and integrating throughout the day. Atypical children with autism often do need more direct instruction.*
- *It would also be considered to be a natural environment if a child were served in a childcare center (or other location), if that is where the child has been placed by the parents, and the child needed support there. This service should also involve family collaboration and/or training as well. It seems that a good definition for natural environment is the environment where the child is or would be if the child was not a child with a disability.*
- *In the programs I work with, these are standard practice for their services. However, I do NOT believe they are "routine" in the majority of programs/services.*
- *Parents are not always given information about ALL service options. Goals and action steps written by point of entry offices are routinely not functional but represent services. Family circumstances (i.e. Both parents working) greatly effects primary place services should be provided.*
- *Home visits are most beneficial when the EI team work with the parent by demonstrating with the child in a positive way, using terminology the families understand, and providing families activities to work on through out the week.*
- *Regarding the second bullet, a system to measure questions 1,3,4,5 would provide a more accurate picture. At present, those questions appear subjective based on the agency answering because not all agencies have a consistent way of determining the success other than level of achievement of outcomes or care-giver report.*
- *It is the responsibility of the service provider to model child activities for the parent, then help the parent learn any techniques necessary to carry out activities during the family's routines.*

- *Who are the "caregivers" in this statement? Also most DMR service providers provide great home and community based services where parents participate naturally – "most" therapists are more likely to provide pullout. Susan Tuck provides consultative in the home of the family where the family learns the skill necessary to care for their child.*

❍ Child progress is effected most positively by

o Hands-on time with specialists, therapists or teachers for each relevant area of delay.	3.72
o Consistent consultative work with families and other caregivers.	3.31
o Learning that occurs between consultations with caregivers.	2.72
o A couple of therapy sessions per week.	2.49
o 10 minutes of skill development during each waking hour in a child's day.	2.21

Comments:

- *A child's progress is best enhanced by a cooperation between parent, therapist, and teacher.*
- *If the family is well informed and are capable of carrying out the therapist or EI teacher's suggestions – coupled with their direct services, this is the best scenario I think.*
- *For the skills to be functional, the activities need to be done during daily routines rather than in isolation.*
- *I would hate to see any regulations that give a specific number of visits or state that a certain amount of time each day is "best". Every child and family is unique and the regs need to be flexible.*
- *Families can often most impact their child's development by assistance in identifying routines during the day where they can be taught how to use those times for working on skills. Preschool centers that are cognizant of and minimize the same routines can impact the child's development tremendously.*
- *While families are a child's most important natural teachers, families should be allowed to enjoy family time with their child, rather than always being in a therapeutic mode. Some families are better positioned than others to be the primary source of intervention, particularly taking into account socioeconomic factors.*
- *There are direct techniques that therapists use which require assessment skills that cannot be taught by "consultation." These techniques, i.e. NDT, PNF, etc. – take special training and <u>are</u> <u>proven</u> to work if done correctly by a trained therapist.*
- *Is 10 minutes of skill development during each waking hour realistic and achievable? I doubt it.*
- *There is no correct answer to this question. It is often necessary to have the input and the direct therapy from the specialist and then work in conjunction with the home interventionist to adapt throughout the day. I am concerned that many home interventionists do not have the background and training to effectively carryover appropriate goals to the home.*
- *Consultative work with families and other caregivers may work in cases where the child doesn't have delays in multiple domains. In those cases the child needs direct attention more than once a week for one hour.*
- *My rating for the last statement above applies to skill development within the course of natural routines, the time whether it be during each waking hour or embedded during naturally occurring routines in more limited timeframes. Therapy a couple of times a week in conjunction with training families may be appropriate for some children. The individual needs of all children must be considered in any state model of service delivery.*

- *Learning occurs in ALL settings and at ALL times. Therefore, it can best be supported and promoted by EVERY caregivers' interactions.*
- *Child's progress is most positively affected by collaboration between ALL team members.*
- *Initially, a couple of therapy sessions may be needed with the intent to move to consultation quickly.*
- *The last one seems like something that doesn't really happen – our instructions are more like "practice eye contact during diaper changing time; practice letting go of objects during bath time" – more routine based.*
- *Parent involvement is key in the child making progress. Any instruction or family training that occurs with the child and family present is key. No one party should be left out. In my experience, direct therapy works best with children who have articulation problems related to speech. PT, PS, OT should be provided consultatively for all children birth to three.*

❍ A group setting qualifies as NE if Direct Services are provided

- To one child at a time within the group. 2.15
- Only a professional OT, PT or Speech/Language therapist or teacher. 2.49
- By para-professionals working with one child at a time. 2.21
- When the caregiver recognizes the opportunity to work with a child throughout the day based on cues from the child. 2.15

Comments:

- *Again, different children respond differently in various settings. The Sp T, OT and PT give good advice and suggestions to EI paraprofessionals to reinforce skill development.*
- *A natural environment should be defined by the family and the child's needs not the State defining what a natural environment is or isn't.*
- *Not necessarily working with one child at a time, but working with all children within the context of the group.*
- *A natural environment is defined as the one in which the child would be if s/he did not have a disability, not by the services provided in that setting. Obviously, the last item describes an ideal setting, but I don't believe that offering direct services one on one within the group setting cancels out the natural environment component.*
- *An adult can still teach a child even if not given a cue by him or her and likewise a child can learn even if he/she does not give a 'cue."*
- *Direct services can be provided in a NE in a group setting by professionals, paraprofessionals, and care givers if appropriate instruction is given.*
- *Not sure what this is asking. If a provider goes out to a child care facility and works with a child within the group to make the child more successful in that environment it should be counted.*
- *The last comment is a five assuming that the caregiver or professional embeds the required or necessary interventions or strategies to address all of the identified goals of the IFSP in a planful manner, not just based on the cues from the child.*
- *The purpose of using a group would be to provide training that addresses the needs of a child within a "typical" group setting. It could be supported by a caregiver directly interacting with the child to insure their participation.*

- *Caregiver could be any team member from child's team.*
- *A group setting qualifies as a NE when you have typical peers in the group and all of them are doing the same (ex: everyone is eating snack together, everyone is participating in circle time together).*
- *In a natural group setting, structure and equality is important. Direct services should be provided within a group setting incorporating a group activity with typical children and there to enhance the activity by supporting the caregiver.*
- *Group setting such as child care programs work best for NE if the EI teacher works with the child with this friends in attendance and as a consultant with the child care teacher. No direct skill building that is not natural to the environment such as rolling on a ball for PT and no one else is doing that.*

❍ A service is NE compliant if it is called

- Family Training. 3.38
- Special Instruction. 2.41
- Either one because they are the same service. 2.82

Comments:

- *In a home-based setting, these services could overlap. Meeting the family and child's need is what's most important. I don't think limiting these options would be beneficial.*
- *A home visit is really a home visit calling it something different or using a name based on the funding source for the home visit does not change what goes on at the home visit. As both a previous DMRS home visit teacher and a previous TIPS parent advisor when you walk in the door and the child needs food or diapers, but you had planned to demonstrate fine motor skills with the parent that day you have to do what you have to do; family needs come first. No one agency should have a monopoly on home visitation.*
- *Family training and the special instruction are NOT the same service.*
- *What a service is called does not make it compliant. What a service provides and in what manner is what makes it compliant. Either of the above could be compliant or non-compliant and they could be the same or different.*
- *Special instruction by a qualified teacher can occur during the course of the day in an inclusive preschool setting, monitored consultatively by a therapist, if the preschool day is set up include the natural routines that would occur during a toddler's day; snack, free play, outdoor time, interaction with an adult and other children.*
- *The title of the service does not necessarily mean NE*
- *I don't believe that EI should expect families to be trained into becoming service providers. Special instruction, to me, refers to specially designed services/instruction provided to the child. While the best-designed program provides opportunities for interventions throughout the natural routines for the day, and while families should always be the director of services for their child, families should be able to choose the option of direct services provided by someone other than themselves.*
- *Competent special instructions should include family training.*
- *We need to remember that the definition of Special Instruction includes parent or caregiver education. All the providers I know include training as part of special instruction. Family training in this state has been looked at as working with the parent information without the child having to be present. I think we need to redefine the terms so all service providers are clear.*

- *The name of the service has been an issue of confusion in our state because we attached the service names to different organizations rather than looking at good definitions of services which may be provided by multiple agencies. ALL special instruction should include elements of family training. The family training category of service may be more appropriately used when the family needs highly specialized training like attending sign language classes to learn to communicate with their child who is deaf for example, or a family who needs training specific to a certain AT device or behavior training, etc.*
- *Either one is appropriate IF it is offered in the natural environment.*
- *No opinion regarding above statements. Natural environment should ALWAYS be specific to family circumstances and needs.*
- *NE is NOT a service, it is a place where the child is most comfortable (home, family's home, childcare, etc). If it is somewhere outside a home, typical peers need to be involved.*
- *Not necessarily. Family Training and Special Instruction are not the same. To be compliant, both must incorporate a family training component with direct involvement from the family. However, in the state, the difference is shaded because of interpretation of the law. If Family Training were implemented based on the true definition, it would be compliant. Special instruction could also meet the NE requirements if provided in a setting that meets NE requirements, included the FT entity, and compliance requirements.*
- *The location defines the environment -both services could or could not be, depending on where they occur. Special Instruction <u>includes</u> Family Training.*
- *A service is NE compliant if the service occurs in the child's natural environment e.g. home child care center or other place the child typically frequents. NE is not tied to a title of a service. NE can happen with a person who provides both Family Training and Special Instruction if the place is appropriate. Family Training in Tennessee has been used inappropriately for years and has been more confusing to service providers. TIPS is family training only though they provide Special Instruction? EI direct service providers are required to use Special Instruction though they do Family Training. This is the result of duplication of services!!!*

❍ The State is performing at the greatest level of compliance with Federal NE requirements possible. **3.49**

Comments:

- *We serve natural environments, some agencies still do not.*
- *This is only a problem for us if the parent is not comfortable with someone in their home and in order not to lose the child we have to write a justification for it.*
- *Parents don't appear to have choices about their home visiting agency, if a family prefers home visitation for their early intervention service it shouldn't go exclusively to TIPS.*
- *More therapies need to be provided in the home or other NE settings.*
- *I only know what our program is doing. I cannot answer for the State.*
- *The developmental preschools have made great strides in integrating classrooms. It's still important that settings exist, as mandated by Part C, which were not designed for children with disabilities but which include and support those children. This speaks to well supported community-based programs.*
- *Not all insurance companies allow NE visits.*

- *For early interventions (special instruction/family training) our state is in compliance. With therapy services, we are not because the system is not set up to provide appropriate reimbursement and due to time constraints.*
- *Our state has taken a proactive step in requiring B-3 centers to serve children who are typically developing at a ration of at least 50%, however, in natural environment has long been viewed as having children in centers around other children, rather than having children receive services in the place where they would be if they did not have a disability.*
- *The state mandate EI begin community-based services, which resulted in the majority of special instruction/parent training being done in the home and/or inclusive group settings. However, many group settings remain "specialized towards the child with delays and therapies are most frequently being provided in clinic settings.*
- *Opportunities for services that could be provided in inclusive child care settings are rare but would be incredibly beneficial to many children and families.*
- *There are not enough providers who will offer services in the community, which means services are being met in a clinic which is not NE. Often times, children will learn skills in the clinic but are not able to carry them over into their natural environment.*
- *If all programs, including contracted agencies from the medical model, were following the compliance of Federal NE requirements, the answer would be 5. But reality is not so. The system is driven by individual agency procedures and contracted providers are more medical than educational.*
- *The EI District has a large % of children who get therapy at clinics. Programs that provide Special Instruction are almost all (over 90%) in the NE, but many children get <u>most</u> of their services at a clinic so it will show up as "service provider location."*

(2) Service System Options. It has been suggested that there are a number of direct service options from other states that warrant implementation in Tennessee.

- In my opinion, knowing that much more information is needed, the State should
  - Pursue TennCare/Medicaid reimbursement for Developmental Therapy, a service similar to Special Instruction. 3.46
  - Permit Developmental Therapy and Family Training to be provided by the same person. 3.46
  - Expand the MCO networks with qualified Early Intervention Specialists.

Comments:

- *I think there's much more info needed. Is TN not up to par or is someone ready to change something that isn't broken? We see progress in our children and I'm not aware of any major compliance areas. I guess I don't understand the need to fix something that's working.*
- *Consultative therapy should be pursued, it is awful parents and children are sitting in rehab centers to get therapy.*
- *I'm not clear on what Developmental Therapy includes. This is the first time I have heard that term.*
- *I would only permit Developmental Therapy and Family Training to be provided by the same person if they were not billed as two separate services. If they are billed as two separate services, then the billing needs to reflect that–for instance, a one hour visit would be billed a thirty minutes of Developmental Therapy and thirty minutes of Family Training. As to TennCare reimbursement, I would personally be wary of that due their poor record of payment.*

- *I agree with the second bullet with the provision that the person providing the training is qualified to do so.*
- *Having one person deliver more than one service will only work if the person is qualified.*
- *I am not familiar enough with the distinction among these terms to comment. I would think that theoretically, those training families should also be successful in providing direct services to children.*
- *I feel that the State should thoroughly research competency issues before reimbursing Developmental Therapy. Single service providers for children with complicated diagnoses such as EP or autism would need significant amounts of training to prevent a "watering down" of overall service. I fear that the concept of "first, do no harm" would be in jeopardy.*
- *This is already being done.*
- *I am cautious with my answers above, and want to qualify my position that services MUST move away from the technical medical model that we are currently utilizing and become more developmentally and routines oriented.*
- *If Medicaid is being requested to provide such services, ALL insurance companies should also be utilized. Otherwise, it seems discriminatory – which already occurs when TennCare is the Child's insurance resource -and would appear to further burden an already over-taxed system. Are these services not ultimately the responsibility of DOE?*
- *What exactly is developmental therapy? Need to see clear definition.*
- *The State should look at other states. However, Developmental Therapy must be clearly defined. Family Training is clearly defined in educational circles to be included as a component in each instructional strategy. If Developmental Therapy is currently a billable service, who is providing that service in MCO networks currently? Are those positions considered Case Management? If so, those persons should be qualified EI specialists.*
- *TennCare can't afford this. Funding is already in place through DMRS and DOE. *Special Instruction already includes Family Training.*
- *Think involving Medicaid and TennCare will bog us all down with paperwork, medical decisions about EI care, and also keep families from getting the services they need because they are tied to an approved amount and that is all they will reimburse.*

❍ Since Part C prohibits services after age 3, when a child with an IEP turns 3 by 4/31, the family should

- Be permitted to remain in EI only on a limited basis until school begins. 4.15
- Not be permitted to remain in EI. 1.62

Comments:

- *This makes much more sense than the break in services unless the school system decided to provide summer prs. Services for 3 & 4 year olds.*
- *In an effort to have a more seamless system.*
- *I would like to see EI services provided for families at least until age 4 and preferably until age 5.*
- *Currently, DMR gives a waiver for children with birthdays after 4/1 (I think). The child's IEP is in place by their third birthday and the school system starts paying for therapies covered by TEIS, but Home Visits and /or Center Instruction are able to continue until the fall when the school preschool stats. I feel that this is family-friendly and in the best interest of the child and should continue.*

- *Expansion of services to age 5 would be best options; often children are not identified as delayed until they are 24-36 months, and just begin intensive services, making significant progress, and then turn 3.*
- *Families really get caught by the timeframe in which their child turns 3. Absolutely children should continue receiving services until the school system begins to serve the child.*
- *Carry over of services through 3-4 months is important – it is a large percentage of the child's life!*
- *Smooth transition should be the goal. If school district is unwilling or unable to provide immediate appropriate services the day a child turns 3, then it is appropriate to continue EI services to the extent that progress continues and regression is avoided.*
- *This decision needs to be made by the IFSP and IEP team. It is very important to know if the child will be eligible for extended school year for summer options so they do not go without services if they transition to the LEA.*
- *Ideally, if we could use the birth to five state option in IDEA to serve 3 year olds, we would then have more natural options to serve 4 year olds. Four year olds are usually viewed as preK students and are traditionally served in "academic" or classroom settings. Three year olds are still developmentally very young and more routines oriented. I am not sure if the B-five option can be used for a subset of the B-5 age range. If not, it is still an excellent option as long as we promote transition to kindergarten appropriately. My limited understanding is that in states where children are served b-5 transition to school can be more difficult than at three because of two additional years of EI type services, forming even stronger bonds and resistance to change. Regardless of the system, there needs to be a better understanding and support across agencies and systems to promote smooth transitions. To often lack of understanding or a mindset of service projects a negative image of transition. That being said, there are still unfortunate situations of difficult transitions, though we are very focused as a state toward addressing this issue.*
- *Continuation of services facilitates the child's transition into public school.*
- *The cut off date should be 2/28 or 3/31, otherwise you run into the problem of children only receiving 2-4 weeks of service before summer break. This could be a detriment to children who have just adjusted to the new environment, or to children who are still adjusting and the break could create a huge regression in skills.*
- *Tennessee prohibits services after age 3. If the state continues to follow the current practice of dividing EI into 2 groups 0-3 and 3-5 then the LEAs must take responsibility for those children whose birthdays fall within May-August. The ongoing development of babies does not follow a 9 month school schedule. Those children should be allowed to receive some EI services through the LEA during those time periods if the IEP team feels the child would be at risk for regression without EI intervention. If the state elects to change the current practice and make the EI system 0-5, as in many other states, there would be no issue regarding 3rd birthdays and the LEA schedule.*
- **This is an IEP team decision – It should be done case by case.*

(2) Consultative Approach for Therapy and Specialty Services. TEIS promotes the Consultative approach for therapies so that caregivers learn to interact knowledgeably with a child throughout the course of daily living. This model is currently being successfully implemented in several states at both the program- and child-specific levels.

- In your opinion, the Consultative Model is
  - Direct therapy by multiple, individual professional disciplines to families and caregivers who then work with a child. 2.82
  - An integrated approach to consolidate a range of developmental skill-building strategies through one qualified consultant who works with caregivers. 3.51
  - An approach in which individuals are trained in multiple disciplines. 2.85

Comments:

- *DMRS has funded this option for over 20 years by contracting with Susan Tuck, PT, out of Developmental Services in Dickson, but recently Steve Norris cancelled this contract and we have lost this wonderful effective model.*
- *Some children actually do need therapy by a therapy by a therapist and not by the consultative model.*
- *A teacher "trained in PT, OT and Speech is not "Qualified."*
- *While some children who are currently receiving direct therapy services could increase their skill without frequent visits to a skilled professional, others need frequent (once a week or more) direct therapy. Please be careful to not develop a "one size fits all" plan.*
- *Not so much trained in multiple disciplines, but naturally occurring routines and events in a child's day where the necessary skills can be incorporated. For example, in an inclusive preschool, therapists consulting with the teacher to identify and shape skills and behaviors so those skills can be incorporated into the child's typical preschool/daycare day.*
- *For school age children, the consultative model refers to therapists and practitioner providing guidance to the classroom teacher. I would agree with the 2nd definition given, except that more than one "qualified consultant" might be necessary, depending on skill levels and expertise.*
- *A consultative approach is not appropriate for every child. As a professional, I am trained to implement strategies and techniques that are proven and documented. Obviously, the think tank that implemented the consultative approach never investigated each proven technique used by PT, OT, and ST's for at least 100 years.*
- *I think the practical approach is to consider all these options and deliver what is appropriate and doable for the child and family.*
- *It may always be necessary to model interventions directly with the child for the purpose of demonstrating and/or training families and caregivers, or for expediting certain skill acquisition. As for individuals trained in multiple disciplines, I would agree that individuals trained to provide services across disciplines - generalists like developmental interventionists, or teachers who have the ability to address the needs of the child as a whole, taking into account any intervention specific to a particular domain or need, like speech therapy or mobility would be a desired delivery model. Those providers would, at the request of the IFSP team, integrate information from specific professionals like SLP's, OT's etc., as needed. In some cases the SLP or other professional would be the lead, but they would have to be able to address aspects of the needs of the whole child within the context of the family.*
- *The words "direct therapy" give the impression that treatment is given to the child? If individuals are trained in multiple disciplines means "trained by consultants" this is appropriate.*

- *I have yet to hear or read true evidence of the true success of this model in other states from the front-line people responsible for implementation. The above ratings express our understanding of the model not our agreement with the statements.*
- *It would be ideal if one provider could consult (along with parent) with therapists periodically to implement strategies in the natural environment/daily routines.*
- *Consultative therapy works for all therapies. Also it works best when the therapist works with the EI teacher and trains them on what to look for on weekly visits. Foundations Early ntervention Services does this well in collaboration with Susan Tuck.*

- In your opinion, benefits of the Consultative model include:
  - One qualified person assists families to learn the best ways to work with their children. 3.31
  - It is an efficient, practical way to give caregivers needed skills. 3.82
  - It is the equivalent of a "Train The Trainer" model so multiple caregivers become skilled. 3.69
  - It is appropriate for in-home services. 3.97
  - It is appropriate for group settings. 3.85
  - It is appropriate for young children who typically have limited attention spans. 3.64
  - Reducing the time required to be set aside for specialized services in an already busy day. 3.36
  - Extending a professional's reach to more caregivers. 3.72
  - Extending the reach of professionals in disciplines where access is limited. 3.74
  - Cost effectiveness. 3.77

Comments:

- *Some children, especially medically fragile ones, need more than 1 person can give.*
- *Again, the child's best fit is my main concern. I believe limiting the approach would not be in the best interest of the children.*
- *I used this model very effectively in Texas with assessment teams consisting of OT, PT and SLP who visited the rural county once a month and either met at a church site to see multiple children scheduled throughout the day or visited a child at their home both ways parents and the special instruction teacher who would carry through with the recommendations were both present.*
- *I just want to be sure that you are not considering taking therapists out of the picture completely. While I feel that I am able to perform many PT, OT, and ST activities, I do not have the medical background necessary. It would be negligent for a therapist to advise a family or caregiver on activities to do with a child if they have never laid hands on that child.*
- *The consultative model cannot be a "one size fits all" approach. There are many, many skills that must first be introduced in a one-to one setting, and can only be shaped in a one-to-one setting, but can be practiced and given multiple opportunities to practice within a preschool/daycare or home setting.*
- *Scored 3 because not fully aware of all details.*
- *PT's, OT's, and ST's have a profession and possess knowledge of skills, assessment, ant training. Each parent can be taught a home program based on routines but not all techniques can be taught unless the parent has specific anatomy knowledge.*
- *Consultative can be beneficial on an individual basis. It should not be limited to one person doing training over a variety of one (fax not readable)*

- *I can appreciate the cost effectiveness assertion as far as program operation goes. As to whether it is beneficial and cost efficient in the long run with regard to acquisition of skills by the child is not known to me.*
- *Very dependent on the consultant. Needs to be qualified professional who understands his/her skill knowledge and knows when to gain assistance from other specialists. A little bit of knowledge can be dangerous, especially with children with feeding problems. ASHA does not allow the training model.*
- *One "qualified person" WOULD be appropriate to assist families in carrying out the instructions from multiple consulting professionals, as determined by the child's needs.*
- *We have no opinion on "blanket" consultative model as service delivery model for every individual child and family. Service delivery should always be based on individual child and family needs.*
- *The time factor is crucial. Some mothers and babies are spending 8-10 hours in the car each week just to get to and from a clinic for therapy, and it is ridiculous. Also, in this area, many therapists do not allow parent to watch or participate in sessions, which is a total waste of $ and time in my opinion.*
- *EI teachers along with a consultative therapist works best. A consultative therapist may work well alone, but who would provide the other needed social services and service coordination for the family? TEIS?*

- In your opinion, limitations of the Consultative model include:
  - Limited ability of caregivers to acquire appropriate developmental interactive skills. 3.13
  - The amount of time it takes to instruct caregivers rather than work directly with children. 2.46
  - It is difficult for professionals to trust families' and caregivers' skills. 2.64
  - Too few therapists and specialists embrace the model. 3.77
  - It is not the way services have traditionally been provided. 3.49

Comments:

- *Consultation 1 x month will not be effective for most of our families.*
- *We've used consultative services in the past. I don't believe it is always the best option for some children and families.*
- *It is traditional for most DMRS programs at least in Middle TN area.*
- *TIPS has always provided services that involve families learning how to interact with their child in such a way as to improve the developmental delays of the child.*
- *We all work with some families who are very capable of understanding and carrying through with therapist suggestions. Other families either do not understand or are unwilling. Most families have never had to deal with a child with a disability–and we see them for a maximum of three years. While this might all be very familiar and comfortable to us, it is not to the family. Many families do not want to make their child cry–and some needed activities (such as stretching) may make the child cry. During this re-organization process, please keep in mind the age of the children and the inexperience of the families with whom we work.*
- *People always have difficulty with changes, and seeing the benefits in progressive changes.*
- *Therapists do not embrace the model because "consultation" to caregivers who then work with the child means less billable units for therapists.*

- *By embracing the consultative model, this suggests that I can teach a parent what it took 5 years of college and numerous continuing education hours to complete. This places a huge responsibility on the parent i.e. -"teach your child to walk"*
- *Additional limitations: 1) some families won't respond or be able to comply with this training; 2) some children need direct services due to severity of diagnosis or medical conditions. You can't always separate educational from medical needs.*
- *In my experience -many therapists are not well trained in the area of Birth – Three – many only have limited experience and many only have experience working with the Adult population.*
- *I think many therapists would love the opportunity to engage in the consultant model if they had the time to travel, time to 'train' other professionals, time to work with families at home and a reimbursement strategy.*
- *It must be considered that a combination of direct service to the child in conjunction with training the parent is a balanced model. The parents should not be expected to become therapists, rather, the parents would benefit from learning specific interventions or strategies to address IFSP outcomes, and/or to promote generalization of skills into everyday routines. In some cases more direct contact of the child with professionals may be required.*
- *Therapists continue to be trained in the medical model of treatment and have difficulty believing that consultation WORKS! Time, travel, and financial considerations are also factors to their compliance.*
- *See comments in previous section - We have no opinion on "blanket" consultative model as service delivery model for every individual child and family. Service delivery should always be based on individual child and family needs.*
- *The professionals need to model with the child to the parents, so the parent/caregiver knows what to do and what to look for.*
- **At our agency we have used this model in the past when special grant $ was available for consultants, but that money is gone.*

- In your opinion, the following are critical components for a Consultative model:
  - IFSPs with functional goal statements. 4.46
  - Standard training curricula across disciplines for qualified consultants. 4.10
  - Program managers in centers ready to receive consultation and implement strategies. 4.03
  - A structure for oversight and accountability of consultants. 4.36
  - Champions from within the professional disciplines to promote the model. 4.21
  - Easily accessible data base. 3.92
  - Working group of front line caregivers to provide input and feedback about the consultative process. 4.21

Comments:

- *It obviously hinges on who the "champions" are.*
- *This would be very helpful.*
- *An Effective feedback loop between consultants, caregivers, and families.*
- *I strongly disagree with the consultative model.*
- *Quality assurance and accountability are vital.*

- *We need home interventionists who are qualified and have experience in early intervention (not school aged), who work full time at this profession (not just an additional job).*
- *Not sure that I understand the second point – training curricula that is not individualized is not appropriate. The state has adopted early learning standards for children birth through kindergarten. Any intervention should be based on those standards as well as developmentally appropriate practice.*
- *It will be absolutely imperative that training is provided to "convince" consultants that the model is appropriate. It must also be understood that direct services – as a general rule – would not be supported. It would also be extremely important to have consultants linked to the child's primary EI provider.*
- *Above are all critical components for any program providing multiple service delivery options to meet individual needs.*
- *It is key to work with people who have been providing consultative therapy, like Susan Tuck.*

- In your opinion, the Consultative model can be readily implemented effectively now in
  - in-home settings. 3.64
  - Group-based settings. 3.77

- In your opinion, the Consultative model is appropriate for
  - Most disciplines related to Health, Mental Health and Child Development. 3.79
  - Only for disciplines with few professionals available in areas such as Infant Mental Health. 2.46

Comments:

- *I think it would take some time for training. Who sees the children while we're training?*
- *Just so that the choice is not Consultative (meaning that the child does not see a therapist regularly) or nothing.*
- *If the consultative model is intended to address shortages of qualified services providers, and is a means to guarantee some sort of services to families who might otherwise go without, go for it. I don't think that it's a substitute in each and every situation for direct professional interventions and family training.*
- *I do not agree with the consultative model. I am a firm believer in knowing the anatomy of the shoulder in order to help a child reach for a toy, especially a child with CNS damage.*
- *There should be several models available to serve family's needs. A good "direct intervention" approach includes consultation & family training and should be available as a measure of services to meet each family's needs.*
- *We are not ready to implement this model yet because there are too many questions about qualifications, reimbursement, consulting/paying therapists etc. We need to find highly qualified professionals.*
- *The first item is a two because it may be difficult for providers to provide services in the home for reasons beyond their control like insurance reimbursement. Some providers may be resistant to this model, and it may not be cost effective for providers.*
- *I firmly believe that the majority of a child's needs can be met with consultative services.*

- *A word of caution regarding consultative model. If implemented, this process within the state will take time to train and move current EI specialists thinking processes into the consultative model. There must be careful planning and listed qualifications for persons implementing a curriculum.*

(2) Family Empowerment. An expectation of the Early Intervention system is that families are "empowered" to assume increasing responsibility for their child's development and the family's welfare.

- In your opinion, family empowerment is
  - A concrete value that can be observed and measured. 3.08
  - A moving target based upon individual families' competencies and capacities. 3.87
  - A value for which there is a standard that all families can achieve. 3.00

- In your opinion, these are characteristics of family empowerment: Families
  - Make independent, informed choices about family matters. 4.23
  - Assume responsibility for mastering developmental skill building strategies. 3.92
  - Display competence and confidence as caregivers. 4.28
  - Call a service coordinator to help access health and related services. 3.41
  - Ask for information about community services through local health departments, DHS and other agencies independent of a Service Coordinator. 3.92
  - Choose one provider over another to help implement the IFSP based on suggestions Independent of providers. 3.46
  - Set and achieve family focused goals on the IFSP. 4.21
  - Challenge providers about services offered for their child. 3.95

Comments:

- *Set and achieve goals on IFSP - It would depend on the family.*
- *Typically, at the beginning of the family's EI experience they don't have these skills. Service providers should be teaching families how to access services, resources, etc. in their communities. EI should be empowering, not enabling.*
- *While family empowerment is essential, it's going to look dramatically different from one family to the next. If a family is dealing with survival issues, being able to ensure that there's food on the table has to be a higher and respected priority than enhancing particular developmental skills. For some families, learning to ask for help is a vital skill to be acquired. I would reframe the 3rd point to read: "families display competence and confidence as families" - because there may be areas of care giving/instruction/skills development for which professionals/s/consultants should retain responsibility. I would also like to see language related to learning advocacy skills—"challenge providers" is an unnecessarily negative phrase for an important skill set.*
- *The responsibility of the parent should be to love and nurture their child and we should help them help their child. When we place the majority of the responsibility on the parent to help their child walk and talk - this is too much and unethical when we have training to do this ourselves.*

- *Families' abilities, goals, choices, etc. vary to each end of the spectrum, which is the reason that more than one approach should be offered.*
- *Hard to answer this question. Asking for help from a service coordinator does not mean a family is not empowered. For some families, this might be a positive sign of taking initiative.*
- *Not sure what the last comment means.*
- *Family empowerment can look different for every family depending on circumstances! There is no standard!!!!!*
- *Empowerment is obtained by providing families the tools and resources needed to make informed decisions for their child even if those decisions cause the family to access services outside of the EI system. It is not empowerment if a provider strongly encourages them to choose one provider over another. However, if they are able to navigate for services outside of the EI system, then they have become empowered if they are advocating and taking responsibility for their child. Hoorah, mission accomplished. For families with limited abilities to make informed decisions for environmental or developmental reasons, empowerment could be an ongoing challenge.*
- *Families are able to lean to call on their own – that is what we try to work toward in this program.*
- *#2 rating – families need information to make that decision if they have never received services before.*

- In my opinion, for a family to be empowered it is necessary to:
  - Educate families about the range of service options available to them. 4.82
  - Grant all desires expressed during the development of the IFSP. 2.13
  - Inform families about their rights and how to enact them. 4.67
  - Inform families about rules and constraints in the Early Intervention system. 4.41
  - Have a measurable baseline indicator of a family's strengths and needs. 3.49

Comments:

- *I believe the family is the greatest advocate for their child most of the time. If there's a problem, then we become their advocate and do our very best to be sure that child is exposed to whatever enables him to reach his full potential.*
- *Education is a good thing and all individuals who work with the family should be giving them information to help them make better decisions. But an individual can only absorb so much. For example, if a family has just learned that their child has been diagnosed with autism, they are most likely to want lots of information about autism–what it is, what it is not, what can they expect. Not until they have come to grips with the diagnosis are they going to be ready to work on developing picture schedules, work boxes, etc. that might benefit the child and family. Also, if another child is born into the family or there is a family crisis (death, job loss, etc.), that will affect what the family "hears" and how engaged they are in their child's program. All families need to be "empowered", but I have no idea how you can measure that.*
- *There is a key difference between evaluating families' strengths and needs, and judging them. It is absolutely essential that EI services continue to be strength based and individualized, recognizing that there is vast disparity among families in terms of available resources, conditions and support systems. Obviously, it isn't TEIS's job to correct those disparities, but that information must be taken into account.*

- *We should always provide home instruction and guidelines for parents to help children meet goals but we as therapists should take the primary responsibility to train the child to walk, read, etc. by using our knowledge and assessment skills.*
- *Very difficult to assess empowerment because it is a very relative term. Families learn so much through the B-3 system and gain independence and strength.*
- *Those providing information about rights and advocacy must be trained in how to deliver this information in a positive unbiased manner. It is up to all professionals to guide a family through the intricate process of the IFSP. Parents should not have to become experts in the specifics of law to participate meaningfully or to ensure appropriate services for their child. The professionals should always guide families through difficult situations with positive, constructive comments an strategies.*
- *How do you MEASURE family strengths and needs-far too dynamic. Rules and constraints inside EI system keeping in mind that the TEAM makes decisions. Parents should never feel that there are barriers to services. Any barriers or constraints should be eliminated by us (EI system). They should be informed of the process. We should certainly discuss all desires expressed and reach team consensus.*
- *A family is truly empowered will understand the IFSP and transition process related to Part C and the guidelines from the state. Asking for unrealistic desires during the development of an IFSP is not an indication that the family is empowered.*

STAKEHOLDER ROLES identified by respondents.

__**2**__ Family served by TN's Early Intervention System

_10__ Child and Family Advocate

__4__ Provider, Agency Head

_17__ Provider, Direct Services

_17__ Provider, Administrator

__8__ Therapist/Specialist

__1__ Physician

__2__ SICC Member

_13__ LICC Member

__1__ State level Administrator

__3__ Other Interested Party. _____1 Project Coordinator; 1 Principle Investigator; 1 Teacher_____

District Point of Entry Office Position Functions

District Administrator

Leadership

- Support State's vision and provide direction for the District
- Effective communication
    - Oral
    - Written
- Analytical skills in decision making
- Problem solver
- Personnel supervision and management
    - Coaching
    - Team Leader (leading people vs managing)
    - Mentoring (recognizing and fostering leadership skills)
    - Delegation abilities
    - Conflict resolution
- Effective time management

Personnel

- Implementation of State of Tennessee Human Resources policies and procedures
- Hiring
    - Recruitment
    - Interviewing skills and techniques
- Performance planning process
    - Annual performance evaluations
- Assurance for personnel training
    - Required
    - Position specific personnel training
- Staff retention

Community Leader

- Community outreach
    - Implementation of public awareness and child find activities
- Recruitment of early intervention service providers
- Interfacing with community:
    - Families
    - Advocacy groups
    - Local Interagency Coordination Council (LICC)
    - Early intervention community
        - Medical providers
        - Therapeutic providers
        - Developmental service providers
    - State Interagency Coordination Council (SICC)
    - Higher Education

Accountability

- Contract administration
- Budget management
- Implementation of IDEA, Part C and State rules and regulations

- Strict adherence to all Part C Procedural Safeguards and Family Educational Rights and Privacy Act (FERPA)
- Monitoring
    - Continuous Improvement Monitoring Process (CIMP)
    - Internal within the District office
    - Tennessee's State Performance Plan
    - Tennessee's Annual Performance Report
- Tennessee Early Intervention Data System (TEIDS)
    - Utilization
        - Monitoring
        - Reports
    - Oversight of the District Data Manager
- Complaint, Mediation, and Due Process resolutions
- Assurances for timelines
    - Part C
    - State
- Complete personnel training
    - Required
    - Position specific personnel training
- Contribute to a harmonious and professional work environment

Scope of Services Key Functions

- The Grantee shall conduct and document a program of district-wide public awareness activities and participate in other community child find efforts.
- The Grantee shall gather district-wide information for annual update of the state's Annual Report and Directories. The Grantee shall submit the updated information to the State's central collection system in a timely manner and develop and implement a plan for dissemination of the updated Directories/Annual Report to appropriate locations in the District.
- The Grantee shall design a plan for ongoing training and staff development for POE staff and, as appropriate, related agency staff. Any training activities requiring POE staff travels outside the state, other than those initiated or requested by the State, shall require prior approval by the State.
- The Grantee shall, as requested, participate in staff development via Service Coordination training modules specifically related to the Part C system in Tennessee.
- The Grantee shall, upon request, provide progress reports to the State, either in writing or by personal appearance/s, on the current status of compliance with program obligations via the Continuous Improvement Monitoring Process (CIMP).
- The Grantee shall, upon request and to the extent specified, report to the State Interagency Coordinating Council (SICC) or other specified entities, in writing or by personal appearance, regarding the current status of data collection efforts and other district level activities.
- The Grantee shall appoint a representative from the POE office to participate on the District's Local Interagency Coordinating Council or other equivalent interagency planning group organized within the TEIS District.
- The Grantee shall gather and maintain Targeted Case Management (TCM) data related to the district and provide this information to the State to support the completion of required federal and state data collection reports. The Grantee shall provide such information in accordance with the content and procedures outlined in the Federal Data Count forms and TEIDS fields provided by the State.
- The Grantee shall obtain and maintain data relative to the function as a Point of Entry (POE) for the State's early intervention system. The Grantee will compile, maintain, and report information regarding activities related to Public Awareness and Child find Activities, System's Entry, Intake, Evaluations for Eligibility, IFSP Development, and Transition as specified in the Tennessee's Early Intervention Data System (TEIDS) provided by the State.
- The Grantee shall recruit contractual or collaborative agreements with individuals/agencies for the purpose of facilitating timely evaluation/ assessment of children/families and monthly face to face visits by the TEIS service coordinator.

- The Grantee shall provide monthly fiscal reports to the State which reflects all direct services purchased through this Grant as payor of last resort and the cost of such services during that quarter.
- The Grantee shall maintain a system for monitoring the delivery of services purchased via TEIDS data.
- Document that the request has been reviewed, at a minimum, by the TEIS Project Coordinator and, as appropriate, the TEIS Principal Investigator.
- The cost of services approved and paid for by the Grantee outside the criteria specified in this Scope of Service will be the sole responsibility of the Grantee and will not be reimbursed by the State.
- Required Services/Program Personnel Standards:

Required Service	Program/Personnel Standard
Developmental Evaluation/Assessment	Early Intervention Teacher/ Parent Advisor with appropriate education and experience not limited to Deaf Education, Speech, Physical or Occupational Therapist, Child Development Specialist, Nurse, Special Educator, Early Childhood Special Educator, Early Childhood Educator or General Educator with Early Childhood Experience
Vision Assessment/Services	Certified Vision Specialist, Licensed Optometrist, Licensed Ophthalmologist
Speech/Audiology Evaluation/Services	Certified Hearing Teacher, Speech Pathologist or Audiologist with MA in speech or audiology with Pediatric experience
Physical or Occupational Therapy/Eval/Service COTA or PTA	Licensed Physical or Occupational Therapist with pediatric experience. COTAs and PTAs must be supervised by a Licensed Occupational Therapist or Licensed Physical Therapist.
Nutrition Evaluation/ Services	Licensed Dietitian or Nutritionist
Psychological Counseling, Consultation, Assessment	Licensed in Clinical Psych., School Psych., Counseling Psych., Educational Psych., Psychiatry, (LCSW) with experience working with children with disabilities and their families.
Nursing RN LPN	Nurses must have graduated from an approved School of Nursing and have licensure as a Registered Nurse (RN) or Licensed Practical Nurse (LPN). An LPN must be supervised by an RN.
Special Instruction (Center-Based) Full-day (max. 8hrs) Half-day (max. 3hrs) Per hour (two hours or less)	Center-based program licensed by DMRS or located in a local school; must consider experience, proximity, unit cost, and teacher credentials. Priorities should be given to programs that include typically developing peers in programming.
Special Instruction/Family Training (Home/Community Based)	Early Intervention Teacher/ Parent Advisor with appropriate education and experience not limited to Deaf Education, Physical or Occupational Therapy, Vision, Child Development, Nursing, Special Education, Early Childhood Special Education or General Education

District Data Manager

- Support and implement the vision and direction for the State
- Understanding and Implementation of IDEA, Part C and State rules and regulations
- Adherence of State of Tennessee Human Resources policies and procedures
- Strict adherence to all Part C Procedural Safeguards and Family Educational Rights and Privacy Act (FERPA)
- Budget tracking and reporting
- District provider leadership and support
    - TEIDS
    - Data management and usage
- Data Quality Assurance
    - Data entry, accuracy, utilization
- Tennessee Early Intervention Data System (TEIDS)
    - Utilization
        - Monitoring
        - Reports – office, CIMP, State
    - Training and Technical assistance
        - In-house
        - Community providers
- Track Targeted Case Management (TCM)
- Effective time management
- Effective communication
    - Oral
    - Written
- Complete personnel training
    - Required for position
    - On-going in-service
- Contribute to a harmonious and professional work environment

Scope of Services Key Functions

- The Grantee shall gather district-wide information for annual update of the state's Annual Report and Directories. The Grantee shall submit the updated information to the State's central collection system in a timely manner and develop and implement a plan for dissemination of the updated Directories/Annual Report to appropriate locations in the District.
- The Grantee shall, upon request, provide progress reports to the State, either in writing or by personal appearance/s, on the current status of compliance with program obligations via the Continuous Improvement Monitoring Process (CIMP).
- The Grantee shall gather and maintain Targeted Case Management (TCM) data related to the district and provide this information to the State to support the completion of required federal and state data collection reports. The Grantee shall provide such information in accordance with the content and procedures outlined in the Federal Data Count forms and TEIDS fields provided by the State.
- The Grantee shall obtain and maintain data relative to the function as a Point of Entry (POE) for the State's early intervention system. The Grantee will compile, maintain, and report information regarding activities related to Public Awareness and Child Find Activities, System's Entry, Intake, Evaluations for Eligibility, IFSP Development, and Transition as specified in the Tennessee's Early Intervention Data System (TEIDS) provided by the State.
- The Grantee shall provide monthly fiscal reports to the State which reflects all direct services purchased through this Grant as payor of last resort and the cost of such services during that quarter.
- The Grantee shall maintain a system for monitoring the delivery of services purchased via TEIDS data.

The Grantee shall not utilize the funds in this Grant to purchase a comparable service already available at no cost to a family from a state, federal, or private provider, barring extenuating

Special Instruction/Family Training (Home/Community Based)	Early Intervention Teacher/ Parent Advisor with appropriate education and experience not limited to Deaf Education, Physical or Occupational Therapy, Vision, Child Development, Nursing, Special Education, Early Childhood Special Education or General Education Applied Behavior Analysis (ABA): Applicable to discrete trial or any other teaching strategy under that heading. ABA is not an early intervention service covered under Part C IDEA. It is a teaching methodology or strategy. Teaching strategies/methodologies are designed by team members through the IFSP process in support of an outcome. They are specified in the action steps for a particular outcome.
Special Instruction/Paraprofessional	An individual with at least a high school diploma or recognized equivalent involved in the implementation of an intervention program designed by, and under the supervision of, a professional with appropriate (licensed or certified according to Tennessee requirements) credentials for their profession.
Consultation	Including Developmental Assessment, in-service training, IFSP attendance, Staffings, Material Preparation, Public Awareness Activities, meeting attendance for Parent Members on LICC, and No shows for services provided in home/community settings – including FT, SI and therapy.
Transportation	Travel to and from required services may be paid to family members or their designees should transportation be deemed necessary to enable participation in EI services. This may include a one (1) time compensation per family, not to exceed ten (10) dollars, for return of assistive technology devices no longer needed by the child and family. Travel may be paid to professionals providing a required service in a community setting.
Interpreting Services	Proficiency in language including sign language skill, unit cost, experience, credentials, and availability.
Other Services	Including assistive technology, medical services for diagnosis only, and others will be funded on an individual case by case basis.
Exclusion	Services considered for reimbursement must have been approved as required services by the state Scope of Services and state approved guidelines. Such services as Aquatic Therapy, Hippotherapy, Hyperbaric Oxygen Chamber usage, Listening therapy, Music Therapy, Taekwando have not been state approved.

- circumstances. Any such circumstances must be within State approved criteria and shall be clearly documented in the IFSP Conference notes.
- Service(s) shall be purchased from providers whose personnel meet standards established by the State for Part C.
- The Grantee shall not utilize these funds to purchase, or participate in the purchase of, any service or device that is deemed by the State to be experimental in nature and/or not based on peer reviewed research.
- Timely Evaluations and Reporting
- The Grantee shall provide information to all service providers in the district involved in service delivery for the Part C system of the importance of timely reporting of evaluations for eligibility determination regardless of the payor source supporting the evaluation.

Eligibility Coordinator

Leadership - *Assisting Responsibilities* to the District Administrator related to the oversight of Developmental Specialists

- Support and implement the vision and direction for the State
- Effective communication
    - Oral
    - Written
- Analytical skills in decision making
    - Problem solver
- Personnel supervision and management
    - Coaching
    - Team Leader (leading people vs managing)
    - Mentoring (recognizing and fostering leadership skills)
    - Delegation abilities
    - Conflict resolution
- Effective time management

Personnel - *Assisting Responsibilities* to the District Administrator related to the oversight of Developmental Specialists

- Implementation of State of Tennessee Human Resources policies and procedures
- Conflict resolution
- Hiring
    - Recruitment
    - Interviewing skills and techniques
- Performance planning process
    - Annual performance evaluation
- Assurance for personnel training
    - Orientation
    - Required
    - Position specific to Developmental Specialist
- Staff retention

Community Leader - *Assisting Responsibilities* to the District Administrator related to the oversight of Developmental Specialists

- Community outreach
    - Coordinate public awareness and child find activities

    - Understanding and utilizing prevalence data, including 1% and 2% Rank Order Data
- Interfacing with community:
    - Families
    - Local Interagency Coordination Council (LICC)
    - Early intervention community
        - Medical providers
        - Therapeutic providers
        - Developmental service providers

<u>Accountability</u> - *<u>Direct Responsibilities</u> related to the oversight of Developmental Specialists*

- Understanding and Implementation of IDEA, Part C and State rules and regulations related to eligibility
- Strict adherence to all Part C Procedural Safeguards and Family Educational Rights and Privacy Act (FERPA)
- Monitoring
- Continuous Improvement Monitoring Process (CIMP) related to eligibility
- Early Childhood Outcomes Evaluation data
- Tennessee Early Intervention Data System (TEIDS)
- Utilization of and generation of reports
- Assurances for eligibility timelines
- Medical information manager
- Coordinate medical diagnosis outliers
- Coordinate <u>re-evaluations</u> when needed
- Implementation of use of State defined Evaluation tools
- Interpretation of evaluation reports
- Evaluation report writing
- Individualized Family Service Plan (IFSP) participation when needed
- Complete personnel training
    - Required for position
    - On-going in-service
- Contribute to a harmonious and professional work environment

<u>Special note for qualifications:</u>

- Working knowledge of early childhood development
- Working knowledge of family systems
- Administration of evaluation instruments

<u>Scope of Services Key Functions</u>

- The Grantee shall conduct and document a program of district-wide public awareness activities and participate in other community child find efforts.
- The Grantee shall design a plan for ongoing training and staff development for POE staff and, as appropriate, related agency staff. Any training activities requiring POE staff travels outside the state, other than those initiated or requested by the State, shall require prior approval by the State.
- The Grantee shall purchase assessments, evaluation, and direct services for eligible infants and toddlers within the district to fulfill the requirements of the Individualized Family Service Plan (IFSP). All service providers shall be selected on a competitive basis, when practical, with consideration given to special skills, experience with this population, credentials, proximity to family, and unit cost. Services shall be purchased utilizing the following considerations:
- Timely Evaluations and Reporting:

- The Grantee shall provide information to all service providers in the district involved in service delivery for the Part C system of the importance of timely reporting of evaluations for eligibility determination regardless of the payor source supporting the evaluation.

Developmental Specialist

- Support and implement the vision and direction for the State
- Effective communication
    - Oral
    - Written
- Effective time management
- Adherence of State of Tennessee Human Resources policies and procedures
- Participate in performance planning process
    - Annual performance evaluation
- Complete personnel training
    - Required for position
    - On-going in-service
- Participate in coordinated District screening and child find activities
- Interfacing with community:
    - Families
    - Early intervention community
        - Medical providers
        - Therapeutic providers
        - Developmental service providers
- Understanding and Implementation of IDEA, Part C and State rules and regulations related to eligibility
- Strict adherence to all Part C Procedural Safeguards and Family Educational Rights and Privacy Act (FERPA)
- Post referral screenings
- Complete comprehensive developmental evaluations for the determination of eligibility
- Complete re-evaluations when needed for ongoing eligibility
- Adhere to eligibility timelines
- Utilize State defined Evaluation instruments
- Interpretation of evaluation reports
- Evaluation report writing
- Individualized Family Service Plan (IFSP) team participation
- Complete Early Childhood Outcomes Evaluations for Office of Special Education (OSEP) child progress reporting
- Tennessee Early Intervention Data System (TEIDS)
- Contribute to a harmonious and professional work environment

Special note for qualifications:

- Working knowledge of early childhood development
- Working knowledge of family systems
- Administration of evaluation instruments

Scope of Services Key Functions

The Grantee shall purchase assessments, evaluation, and direct services for eligible infants and toddlers within the district to fulfill the requirements of the Individualized Family Service Plan (IFSP).

- All service providers shall be selected on a competitive basis, when practical, with consideration given to special skills, experience with this population, credentials, proximity to family, and unit cost. Services shall be purchased utilizing the following considerations:

Service Coordination Manager

Leadership - *Assisting Responsibilities* to the District Administrator related to the oversight of Service Coordinators

- Support and implement the vision and direction for the State
- Effective communication
    - Oral
    - Written
- Analytical skills in decision making
    - Problem solver
- Personnel supervision and management
    - Coaching
    - Team Leader (leading people vs managing)
    - Mentoring (recognizing and fostering leadership skills)
    - Delegation abilities
    - Conflict resolution
- Effective time management

Personnel - *Assisting Responsibilities* to the District Administrator related to the oversight of Service Coordinators

- Implementation of State of Tennessee Human Resources policies and procedures
- Conflict resolution
- Hiring
    - Recruitment
    - Interviewing skills and techniques
- Performance planning process
    - Annual performance evaluation
- Assurance for personnel training
    - Orientation
    - Required
    - Service coordination training
    - Family assessment activities
- Staff retention

Community - *Assisting Responsibilities* to the District Administrator related to the oversight of Service Coordinators

- Community outreach
    - Participate in public awareness and child find activities
- Interfacing with community:
    - Families
    - Local Interagency Coordination Council (LICC)
    - Early intervention community
        - Medical providers
        - Therapeutic providers
        - Developmental service providers

Accountability - *Direct Responsibilities* related to the oversight of Service Coordinators

- Understand and Implement IDEA, Part C and State rules and regulations
- Strict adherence to all Part C Procedural Safeguards and Family Educational Rights and Privacy Act (FERPA)
- Identify, train, and appoint surrogate parents
- Monitoring
    - Continuous Improvement Monitoring Process (CIMP)
- Tennessee Early Intervention Data System (TEIDS)
    - Utilization of and generation of reports
    - IFSP quality control
- Monitor completion of Targeted Case Management (TCM) visits and documentation
- Assurances for the adherence to timelines within the Part C processes
- Interpretation of medical and developmental evaluation reports in regards to the determination of eligibility
- Individualized Family Service Plan (IFSP) participation when needed
- Assignment of referrals to service coordinators
- Oversight of service coordinator assignments
- Assurance for IFSP content quality
- Conduct family satisfaction survey of service coordinator job performance
- Complete personnel training
    - Required for position
    - On-going in-service
- Contribute to a harmonious and professional work environment
- Assume district administrative functions if necessity required
- Assume Service Coordinator functions if necessity required

Special note for qualifications:

- Prior experience as Service Coordinator or equivalent experience
- Working knowledge of service delivery system
- Working knowledge of early childhood development
- Working knowledge of family systems

Scope of Services Key Functions

- The Grantee shall design a plan for ongoing training and staff development for POE staff and, as appropriate, related agency staff. Any training activities requiring POE staff travels outside the state, other than those initiated or requested by the State, shall require prior approval by the State.
- The Grantee shall, as requested, participate in staff development via Service Coordination training modules specifically related to the Part C system in Tennessee.
- The Grantee shall gather and maintain Targeted Case Management (TCM) data related to the district and provide this information to the State to support the completion of required federal and state data collection reports. The Grantee shall provide such information in accordance with the content and procedures outlined in the Federal Data Count forms and TEIDS fields provided by the State.
- The POE staff shall provide incoming and ongoing service coordination functions, in accordance with Part C of IDEA, for families, including monthly face to face visits that include no less than 15 minutes in direct observation of the eligible child.
- The Grantee shall, when necessary, in accordance with Federal and State Regulations and Procedures, determine the need for a Surrogate Parent for an eligible (or potentially eligible) child. The Grantee shall, when appropriate, identify, appropriately train, and appoint a surrogate parent and submit notification to the State of the action taken. Documentation of procedures followed shall be maintained in the child's record.
- The purchase of services shall be based on the following service principles:

- The purchase of services shall be limited to the evaluation, assessment, and direct services as specified in 34 CFR 303.12 and 13. The purchase of any service under this Grant must be within guidelines established by the State.
- Any service(s) purchased by the Grantee shall support the Outcomes identified for the child and family as specified in a current IFSP that was developed by an appropriate IFSP team in accordance with Federal and State Regulations. The IFSP team must include representation from the TEIS District Point of Entry supported by this Grant. These funds may not be used to pay for services not specified in the IFSP, nor can payment be made retroactively, services provided outside of the IFSP process or for services initiated by a provider prior to development of the IFSP.
- Models of transdisciplinary, interdisciplinary, consultative and multidisciplinary programming shall be given preference in determining and providing appropriate required services for meeting the identified outcomes for Part C eligible children and families.
- The Grantee shall maintain a system for monitoring the delivery of services purchased via TEIDS data.
- Service(s) purchased under this Grant shall be provided, to the maximum extent appropriate, in environments that have been identified as naturally or normally occurring in the lifestyle of the individual child and family (e.g., home, community programs, child care facilities, and other situations/settings involved in the typical routines of the individual family).
- Service(s) purchased under this Grant shall be provided, to the maximum extent appropriate, in environments that have been identified as naturally or normally occurring in the lifestyle of the individual child and family (e.g., home, community programs, child care facilities, and other situations/settings involved in the typical routines of the individual family).
- Service(s) purchased under this Grant shall, to the greatest extent, be provided in a manner that allows the child to be included with his/her typically developing peers. In extenuating circumstances, and when explicitly necessary to promote progress toward a specific outcome in the child's IFSP, the Grantee may provide strictly limited financial support for the delivery of a service in a setting which will allow the child to interact with his/her typically developing peers. Any such support provided under this Grant shall meet the following criteria and must:
- Be requested by the IFSP team, documented on the IFSP, and approved by the Grantee;
- Comply with the Part C provision of "payor of last resort", especially in regard to the exploration and utilization of all available natural supports;
- Be determined not to reduce any effort already in place through any other natural support system (public, private, community, or family);
- Be delivered in settings designed for young children that are appropriately licensed and monitored by the appropriate State Agency (DMRS, DHS Licensed Child Care Centers, Licensed Group Child Care Homes, Licensed Family Child Care Homes, or Registered Child Care Homes, and DOE Approved Child Care providers which are listed with Resource and Referral as Section 504 Compliant) and that meets any criteria established by the Grantee;
- Be secured at a cost that does not exceed the customary cost published by the provider for a child without disabilities;
- Be introduced at a minimal amount with time allowed to determine progress and strictly limited to a maximum of 16 hours per week per child; and
- Be monitored or supervised by appropriate early intervention personnel to guide and evaluate the effectiveness of this support in assisting the child in meeting his/her related outcome/s in the IFSP.
- The Grantee shall not utilize the funds in this Grant to purchase a comparable service already available at no cost to a family from a state, federal, or private provider, barring extenuating circumstances. Any such circumstances must be within State approved criteria and shall be clearly documented in the IFSP Conference notes.
- The following criteria will apply when there is a request for increase in services on a child's IFSP for which TEIS will be the payor. To approve payment for the services under this Grant the TEIS office shall:
- Require each provider to gather information as part of their on-going work with the child prior to making a request for an addition of service or increase in service level to verify that the child or family is not making progress toward Ensure that the Service Coordinator (or the TEIS Project Director if the Service Coordinator is someone other than a TEIS employee) reminds parents of their procedural safeguards if the request for support for the addition of service is denied by the TEIS office.
- Service Enhancement

In developing an initial IFSP or considering an increase in the service level of an existing IFSP, support for a service that will in any way represent a duplication of another service must be provided as consultation to the primary service provider and/or therapist and the family. In the case of two

- providers who could provide an identical or similar service, the provider with the ability to obtain support for the service from a source other than the Tennessee Department of Education will be considered the primary service provider. TEIS support for this consultation will require consideration and approval of the IFSP team and include a written justification with the following elements from the provider:
- The reason/s that this service is necessary for the child to make progress toward the outcomes established for the child and family in the IFSP;
- The specialty or expertise that the consulting provider will bring to the situation that the current provider does not possess; and
- the reason/s why the provider with the area of specialty cannot serve as the primary provider for the child
- The cost of services approved and paid for by the Grantee outside the criteria specified in this Scope of Service will be the sole responsibility of the Grantee and will not be reimbursed by the State.
- All sub-Grants with service providers entered into by the Grantee for evaluations to establish a child's initial eligibility under Part C in Tennessee shall include specific timeframes for conducting and reporting of results to the Service Coordinator. These timeframes shall be such that they will be sufficient to support the determination of eligibility and convening of the initial IFSP meeting within 45 days of the child's referral to the Part C system. Sub-Grant language should also link reimbursement for evaluations to compliance with timelines established in the Grant.

Service Coordinator

- Support and implement the vision and direction for the State
- Effective communication
    - Oral
    - Written
- Analytical skills in decision making
    - Problem solver
- Effective time management
- Adherence to State of Tennessee Human Resources policies and procedures
- Conflict resolution
- Participate in performance planning process
- Complete personnel training
    - Orientation
    - Required
    - Service coordination training
    - Family assessment activities
    - On-going in-services
- Interfacing with community:
    - Families
    - Early intervention community
    - Medical providers
    - Therapeutic providers
    - Developmental service providers
- Understand and Implement IDEA, Part C and State rules and regulations
- Tennessee Early Intervention Data System (TEIDS) documentation
- Adhere to timelines for Part C processes
- Strict adherence to all Part C Procedural Safeguards and Family Educational Rights and Privacy Act (FERPA)
- Complete Targeted Case Management (TCM) visits and documentation
- Conduct routine-based family assessment activities

- Informing and educating families about Part C service options
- Individualized Family Service Plan (IFSP) team leadership
    - IFSP meeting facilitation
    - Coordination of transition planning process
- Responsible for IFSP content
    - Complete personnel training
    - Required for position
    - On-going in-service
- Contribute to a harmonious and professional work environment

Special note for qualifications:

- Intensive Case management experience preferable
- Working knowledge of service delivery system
- Working knowledge of early childhood development
- Working knowledge of family systems

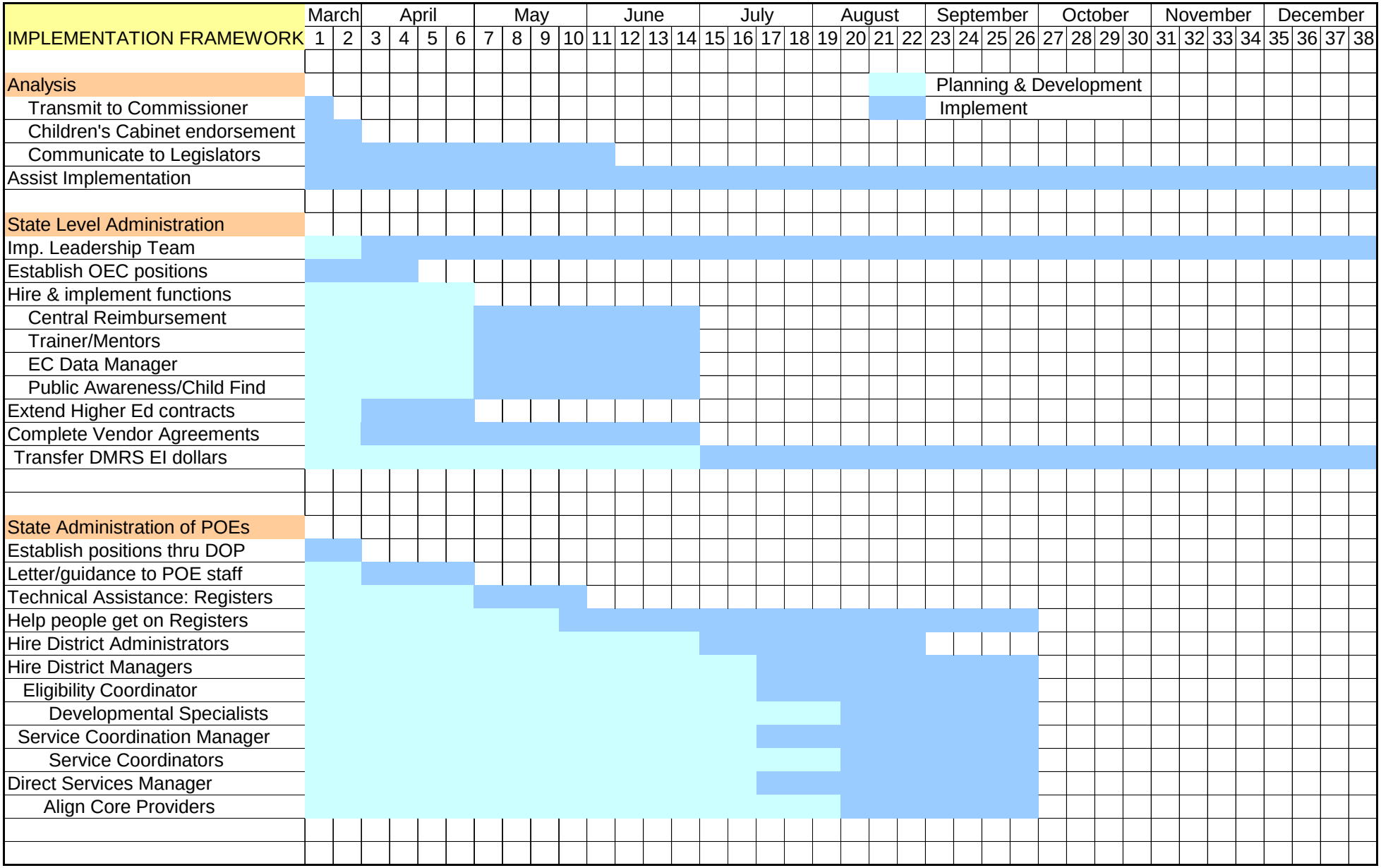
Scope of Services Key Functions

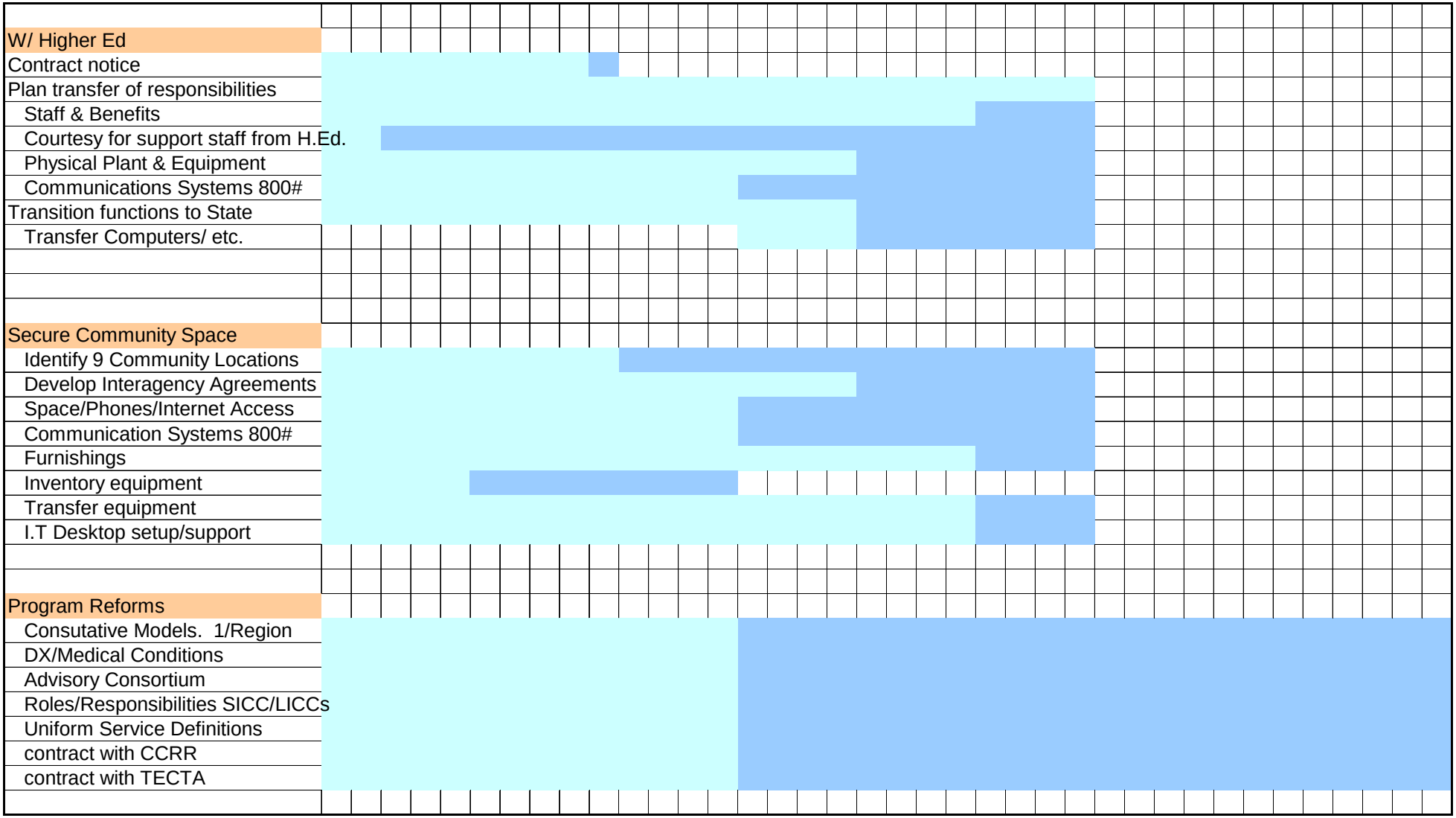
- The POE staff shall provide incoming and ongoing service coordination functions, in accordance with Part C of IDEA, for families, including monthly face to face visits that include no less than 15 minutes in direct observation of the eligible child.
- Service(s) purchased under this Grant shall be provided, to the maximum extent appropriate, in environments that have been identified as naturally or normally occurring in the lifestyle of the individual child and family (e.g., home, community programs, child care facilities, and other situations/settings involved in the typical routines of the individual family).
- Service(s) purchased under this Grant shall, to the greatest extent, be provided in a manner that allows the child to be included with his/her typically developing peers. In extenuating circumstances, and when explicitly necessary to promote progress toward a specific outcome in the child's IFSP, the Grantee may provide strictly limited financial support for the delivery of a service in a setting which will allow the child to interact with his/her typically developing peers. Any such support provided under this Grant shall meet the following criteria and must:
- Be requested by the IFSP team, documented on the IFSP, and approved by the Grantee;
- Comply with the Part C provision of "payor of last resort", especially in regard to the exploration and utilization of all available natural supports;
- Be determined not to reduce any effort already in place through any other natural support system (public, private, community, or family);
- Be delivered in settings designed for young children that are appropriately licensed and monitored by the appropriate State Agency (DMRS, DHS Licensed Child Care Centers, Licensed Group Child Care Homes, Licensed Family Child Care Homes, or Registered Child Care Homes, and DOE Approved Child Care providers which are listed with Resource and Referral as Section 504 Compliant) and that meets any criteria established by the Grantee;
- Be secured at a cost that does not exceed the customary cost published by the provider for a child without disabilities;
- Be introduced at a minimal amount with time allowed to determine progress and strictly limited to a maximum of 16 hours per week per child; and
- Be monitored or supervised by appropriate early intervention personnel to guide and evaluate the effectiveness of this support in assisting the child in meeting his/her related outcome/s in the IFSP.
- The Grantee shall not utilize the funds in this Grant to purchase a comparable service already available at no cost to a family from a state, federal, or private provider, barring extenuating circumstances. Any such circumstances must be within State approved criteria and shall be clearly documented in the IFSP Conference notes.
- The following criteria will apply when there is a request for increase in services on a child's IFSP for which TEIS will be the payor. To approve payment for the services under this Grant the TEIS office shall:

POE Personnel Performance Criteria

- Rate of parents' denial for accessing insurance
- In-service training hours received
- Documentation of District Administrators' leadership abilities
- Staff retention
- Target Case Management (TCM) face-to-face
- Compliance with all timelines
- Continuous Improvement Monitoring Process (CIMP)
- 618 Federal Child Count
- TEIDS
- OSEP Child Outcome data
- OSEP Family Outcome data
- Quality of IFSP content
- Budget accountability
- Budget management
- Staff performance evaluation measurement criteria
- Administration to direct service cost ratio
- Complaints, mediations, and due process issues
- Public awareness/child find plans and activities
- Successful audit of Part C policies and procedures
- Cost per child by service coordinator
- Cost per child by district
- Early intervention service provider recruitment and retention
- Early intervention services in the natural environment

FUNDING SUMMARY						
Rec #	SERVICES	PURPOSE	Reallocated $	Cost Savings	Estimated Revenue	Notes
8a	Streamline Eligibility Determination	23 FTE Developmental Therapists	$1,340,000			
9a	Strengthen Service Coordination	22 additional FTEs w/ = 40 families	1,098,750			60% TEIS children are TennCare eligible; 50% of associated funds = $5M 2:1 match = $10M
11	Developmental Therapy	Medicaid match [formula]			$10,000,000	
17	State Early Intervention Program	Serve 3 year olds ineligible for Part B	2,400,000			
22b	Consultative Approach	Provide financial incentive for therapist	44,000			
22d	Consultative Approach	Provide financial incentive for agency	75,000			
32	SICC	.1 FTE staff support to SICC	7,000			
32c	Family Participation in ICCs	Increase family participation and training	10,000			
	ADMINISTRATION					
4	Child Find Activities	.20 FTE Eligibility Coordinator, 9 Districts	122,400			
6a	Public Awareness/Child Find	1 FTE State Coordinator	81,000			
6b & 45	Publications Coordinator	.5 FTE Coordinator thru Consortium	26,100			
	Printing and Publications		36,000			
7	Public Awareness Plan		10,000			
13a/46a.i	Training and Workforce Development	1 FTE State Coordinator	81,000			
13b/46a.i	Trainers/Mentors	3 FTE State level team	224,000			
14a	Training Events	Workshops, Annual Conference, other groups	45,000			
14c	TECTA Collaboration	Development monies to initiate partnership	25,000			
14d	CCR&R Partnership	Partial support for Inclusion Specialists	55,000			
36	Central Contracting	System of Payments compliance effort		526,710		
36b	Central Billing	4 FTEs State administration	250,000			
39 & 47	Unify TEIS, TIPs and DMRS EI resources	Reduce adminstration from 110 to 54 positions		5,700,000		
39 ii	District Administrator, POE	9 FTE District positions	675,000			
39 iii	District Eligibility Coordination	9 FTE District positions	612,000			Using full model in all 9 districts; adjust for small districts.
	District Service Coordination Management	9 FTE District positions	612,000			
	District Direct Services Management	9 FTE District positions	612,000			
42a	District Data Manager	9 FTE District positions	522,000			
42b	District Administrative Support	9 FTE District positions	324,000			
44	Advisory Consortium	Principle Investigators	252,000			
	Deliverables	Pis and other qualified advisors	90,000			
45	Statewide Technical Assistance	Consultations and technical assistance	50,000			
	Data Management	.5 FTE Statewide data management	35,000			
46a.iv	OEC Data Coordinator	.5 FTE State position w/ Part B	41,000			
50	Fund Expansion	Consultation to complete analysis activities	12,000			


March
April
May
June
July
August
September
October
November
December
IMPLEMENTATION FRAMEWORK
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38
Analysis
Planning & Development
Transmit to Commissioner
Implement
Children's Cabinet endorsement
Communicate to Legislators
Assist Implementation
State Level Administration
Imp. Leadership Team
Establish OEC positions
Hire & implement functions
Central Reimbursement
Trainer/Mentors
EC Data Manager
Public Awareness/Child Find
Extend Higher Ed contracts
Complete Vendor Agreements
Transfer DMRS EI dollars
State Administration of POEs
Establish positions thru DOP
Letter/guidance to POE staff
Technical Assistance: Registers
Help people get on Registers
Hire District Administrators
Hire District Managers
Eligibility Coordinator
Developmental Specialists
Service Coordination Manager
Service Coordinators
Direct Services Manager
Align Core Providers


W/ Higher Ed
Contract notice
Plan transfer of responsibilities
Staff & Benefits
Courtesy for support staff from H.Ed.
Physical Plant & Equipment
Communications Systems 800#
Transition functions to State
Transfer Computers/ etc.
Secure Community Space
Identify 9 Community Locations
Develop Interagency Agreements
Space/Phones/Internet Access
Communication Systems 800#
Furnishings
Inventory equipment
Transfer equipment
I.T Desktop setup/support
Program Reforms
Consutative Models. 1/Region
DX/Medical Conditions
Advisory Consortium
Roles/Responsibilities SICC/LICCs
Uniform Service Definitions
contract with CCRR
contract with TECTA

GLOSSARY

Ages & Stages	A Birth to Three Screening Tool
BDI-II	Battelle Developmental Inventory II
Best Practice	Application of the highest standards known through research or experience to policies and programs.
CCR&R	Childhood Care Resource and Referral
CHAD	Child Health and Development, a home visiting program of the Department of Health that helps prevent or reduce abuse, neglect and developmental delays by providing parent support and education services.
CRO	Central Reimbursement Office, a structure for consolidating administration of contract and vendor services.
CSS	Children's Special Services, a program of the Department of Health for children who have serious medical conditions.
CIMP	Continuous Improvement Monitoring Program, a quality assurance Program of TEIS.
Denver II	A Birth to Three Screening Tool
DOE	Department of Education, designated Lead Agency for Part C of Individuals with Disabilities Education Act.
DOH	Department of Health
DMHDD	Department of Mental Health and Developmental Disabilities, including the Division of Substance Abuse Services.
DMRS	Division of Mental Retardation Services, which contracts with Community Agencies for the provision of Early Intervention Services.
ED	Eligibility Determination
Early Intervention	Services for families of children with special needs for birth to three years which are intended to help the child develop the basic tools for learning: seeing, hearing, moving, talking and thinking.
ECCS	Early Childhood Comprehensive Systems
EPSDT	Early, Periodic, Screening, Diagnosis and Treatment services, a child well-check and treatment program of the Federal Medicaid, state TennCare program.
ESY	Extended School Year
FAPE	Free Appropriate Public Education

GOCCC	Governor's Office of Children's Care Coordination, the office responsible for coordination of a Semi-Annual Report to the Court about the State's compliance with the EPSDT Lay and related Consent Decree, and the principle staff and project manager for the 2006 Analysis of TEIS.
HUGS	Help Us Grow Successfully, a home-based maternal health program of Department of Health.
ICC	Interagency Coordinating Councils, either State (SICC) or Local (LICC), comprised of statewide and local representatives of families, providers and others who have a stake in Part C Early Intervention Services. The purposes of the Councils are to assure local and statewide input and feedback about policy, to coordinate services and publicize availability of early intervention services.
IDEA	Individuals with Disabilities Education Act, a federal law that guarantees an Individualized Education Plan (IFSP) in public school systems for children who qualify for Local Education Agency Part B Special Education programs and an IFSP for children birth to three eligible for Part C.
IEP	Individual Education Plan
IFSP	Individualized Family Service Plan, a plan of developmental services and supports to which a family is entitled if a child is determined to be eligible for Part C Early Intervention Services.
Key Informants	Individuals who were sought out to contribute to the 2006 Analysis of TEIS because of their valuable expertise and/or experience, knowledge, information or data about perspectives of TEIS.
IT	Information Technology
LEA	Local Education Agency
Lead Agency	Department of Education, designated to administer the Part C program.
LICC	Local Interagency Coordinating Councils
MCO	Medical Care Organizations
MCH	Maternal-Child Health
NAEYC	National Association on Education of Young Children
NECTAC	National Early Childhood Technical Assistance Center, a center of the University of North Carolina, the purpose of which is to help states comply with IDEA.
OEC	Office of Early Childhood Programs, the Office within the Division of Special Education, DOE, responsible for administration of Part B and Part C programs, among other responsibilities.

OSEP	Office of Special Education Programs, the federal agency responsible for providing technical assistance and oversight of compliance with IDEA.
Part B	The section of IDEA which sets out the requirements of special education programs to be provided by LEAs to eligible children.
Part C	The section of IDEA which sets out the requirements for coordination of services for families to which they are entitled if their child, age birth to three years of age, is eligible due to developmental delay or serious medical conditions which are likely to result in a developmental delay.
PI	Principle Investigator
POE	Point of Entry, one of nine offices in Tennessee authorized to provide Part C services: Eligibility Determination, Service Coordination and IFSP development.
RLT	Regional Lead Teacher
SCHIP	State Children's Health Insurance Program
SICC	State Interagency Coordinating Council
Stakeholders	Parties who have an interest in the quality, efficiency, effectiveness and accountability for Part C related services and system.
START	Screening Tools and Referral Training, a program to educate physicians and health practitioners about best practices in screening for developmental delays and access to early intervention services.
TCM	Targeted Case Management
TECTA	Tennessee Early Childhood Training Alliance
TEIDS	Tennessee Early Intervention Data System
TEIS	Tennessee Early Intervention System, the name of the State's Part C Program
TennCare	Tennessee's Medicaid Program for uninsured/uninsurable
TIPS	Tennessee Infant Parent Services, an Early Intervention program of the Department of Education.
TNAAP	Tennessee Chapter of the American Academy of Pediatrics
TRIAD	Treatment and Research Institute for Autism Spectrum Disorders

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